THE EFFECTIVENESS OF BEHAVIOURAL MARITAL THERAPY WITH FOUR COUPLES FROM ALCOHOL-COMPLICATED MARRIAGES

A thesis

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by

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I dedicate this thesis

to

COLLEGE HOUSE.

May it continue to be

a place of friendship

and

academic endeavour.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

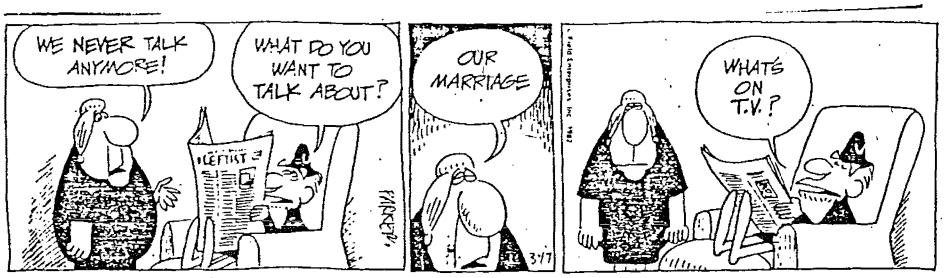
ABSTRACT

The effectiveness of a Behavioural Marital Therapy programme was investigated with distressed couples from alcohol-complicated marriages. Four couples were recruited from the Alcohol Counselling Centre, and received 8-10 weeks of social skills and communication training. The therapy was based on a programme designed by Lynne Haye as part of the Canterbury Enrichment and Social Skills Training (CRESST) project .

As well as a large assessment battery of self-report and quasi-observational measures, a multiple-baseline procedure was used to analyse data from the Marital Happiness Scale; Spouse Observation Checklist; couples' communication and target behaviours. Repertory and Reconstruction Grids were also taken at pre-treatment, post-treatment and one month follow-up to note changes in their perceptions.

All couples showed improvements in self-reported conflict and marital satisfaction. However, there was little evidence of significant behavioural changes in the marriages, following therapy. Due to incomplete follow-up data, no conclusions could be made regarding generalisation and maintanence. The need for marital therapy in the problem-drinking population is discussed and suggestions are made on the most effective implementation of the CRESST programme.

INTRODUCTION



"...communication is closely involved in the establishing and enhancing of a close intimate bond between partners" (p.6).

"Professor Batt, who is the director of the (New Zealand) Medical Research Council's alcohol research programme, said that doctors, instead of talking about the problems of alcohol on physical health, should look more into alcohol causing marriage break-ups and crimes. (Professor defends N.Z. drinking habits, May 26,1984)".

It is widely accepted, though seldom discussed or researched, that problem drinkers as a group have a higher incidence of separation and divorce than would be expected from the general population. This has been documented in North America by Straus and Bacon (1951), Rosenblatt, Gross & Chartoff (1969) and Rosenblatt, Gross, Malenowski,Broman & Lewis (1971). Straus and Bacon sampled 2,023 male alcoholics being treated in out-patient clinics, and found that 27% were divorced or separated as compared to 7% of the general population at that time.

No pertinent New Zealand study was found. However, some available statistics from three treatment centres in Christchurch were compared to New Zealand census figures, which supported this trend. In the 1981 census 67.0% of the New Zealand population 20 years and over were married or cohabitating while 6.9% were separated or divorced. Treatment statistics from the Alcohol Counselling Centre (1982),

Table 1: Marriage, Divorce and Separation Statistics

Treatment Agencies	Year	% Married	% Divorced & Separated
(a) Alcohol Counselling Centre: A statistically representative sample of 50% of all the clients seen during 1982.	1982	38.9% *	26.0%
(b) Mahu Clinic: Admissions between October 1982-March 1983	1982/3	35.8% *	29.0%
(c) Alcohol and Drug Dependence Centre: Total seen during 1983	1983	25.3% *	19.0%
New Zealand Census: Male & female, 20 yrs & over	1966	74.0%	2.3%
	1971	74.3%	3.1%
	1976	73.8%	3.9%
(N.Z. Department of Statistics, 1982)	1981	67.0%	6.9%
Mental Health Statistics: First admissions, in-patient treatment for N.Z. (N.Z. Department of Health, 1970)	1968		
(1) Alcoholism & alcoholic psychosis		48.5%	17.5%
(2) Depressive psychosis & neurosis		62.4%	7.6%
(3) Schizophrenia; Functional and Organic psychoses (except Dementias)		47.5%	5.0%

* Married & Cohabitating

Mahu (October 1982-March 1983) and the Alcohol and Drug Dependence Centre (1983) revealed that between 25-38% were married or cohabitating while those who were separated or divorced ranged between 19 and 29%. Furthermore in 1968 when the Mental Health Statistics were last published with marital status data, 17.5% of the proportion receiving in-patient care for "alcoholism" and "alcoholic psychosis" were divorced or separated, which was twice that for Depressive illnesses and over three times that for Schizophrenia and other psychoses. Only 2.3% of the general population in 1966 were separated or divorced.

These are only crude comparisons as there is no control for sampling bias in these treatment populations. While overseas research would suggest that the proportion of alcoholics/problem drinkers who eventually marry is not significantly different from the normal population, treatment samples often tend to be deviate in age and sex ratios from the population norm (Paolino & McCrady, 1977, p.173-187). Therefore, as well as more males coming for treatment, there tends to be a larger group of younger clients and consequently the percentage who are married is smaller.

For many millions of people marriage, in some form, has been an intimate part of their life, whether through being born into a family or themselves eventually marrying. Marriage is a fundamental social institution of our society. Jack Dominion (1981) discusses it in terms of personal, legal, economic and religious dimensions. There is the personal committment, between two people, to live together, growing and supporting one another. In the legal dimension, society acknowledges the union and places sanctions upon the permanence of it. Children are born into a marriage,

making it the early focus of their development and socialisation. It is an economic system concerned with the consumption of goods and services maintaining a home, and providing clothes, food and other necessities to support the family members. Most religions sanction marriage and provide through their rituals and teaching moral support and direction. It is no wonder that Paolino and McCrady (1977) commented, "...we believe a conjugal relationship to be the most rewarding and yet most demanding of all interactions within our culture" (p.5).

There is an unfortunate tendency for dysfunctional marriages to be self-perpetuating. Haye, Blampied, Church & Priest (1981) studied the transmission of inter-personal difficulties over three generations in a sample of New Zealand families, and reported, "Parents who reported difficulties with their teenagers also reported significantly more difficulties during their childhood and within their own marriage". In behavioural terms children vicariously learn both adaptive and maladaptive social behaviour from their parent models. Research suggests that inadequate social skills acquired during childhood within disadvantaged families are often carried over into marriage and parenthood. Thus subsequent generations are similarly affected.

Not only is this true for social skills but it also seems to be the case in the transmission of alcohol problems. A child from an alcohol-complicated marriage is more likely to become a problem drinker than a child from a non-alcoholic marriage. (Goodwin, 1971; Ablon, 1976; Wolin, Bennett, Noonan & Teitelbaum, 1980). Alcoholism, therefore, has been called a 'family illness'. Ward (1980), discussing this approach, stated, "Just as the alcoholic engages in self-

destructive and harmful alcoholic drinking other family members are caught in the web of self-destructive and mutually reinforcing pathological behaviours. (Therefore) both the alcoholic and other family members need to be treated" (p.4).

It is thus apparent that there is a need for effective marital and family therapy for those affected by alcohol abuse. There are indications that the separation and divorce rate of alcohol-complicated marriages are about three times that of the general population and this may only be the tip of the ice berg of marital and family distress. It can be assumed that there is widespread marital distress amongst the problem-drinking population. What is of evenmore concern, though, is the evidence that through the impact on the innocent victims, namely the children, the effects of alcohol-complicated marriages will continue to the next generation.

The rest of this chapter will attempt to summarise from the research what the behavioural effects of an alcohol-complicated marriage are. Then it will describe what constitutes behavioural marital therapy (BMT) with the aim of showing how BMT can help to treat these effects.

What follows is a short discussion which tries to build up a picture of typical behavioural interaction within alcohol-complicated marriages. The relevant literature is sparse, and the earlier studies are of unknown reliability because they used self-report data and made their interpretations without reference to systematic behavioural observation. Furthermore, in her review Joan Ablon (1976) wrote, "A major failing of previous research had been the lack of control groups and a tendency to look at each spouse as a bundle of pathological characteristics with little sensitive examina-

tion of the marital interaction" (p.218).

Using a survey, Bailey, Haberman & Alkane (1965) found that alcoholic couples reported more frequent disagreements and quarrels than did a non-alcoholic control group. These conflicts often involved physical or verbal abuse, walking out, silence or moodiness and were less frequently settled satisfactorily by alcoholic couples. There were frequent disruptions to normal family life such as meals, celebrations, and holidays, through the intoxication of the problem drinker. Wolin et al (1980) noted that the more profound and frequent these disruptions, the higher the risk of the children developing similar problems.

Several studies have investigated the communication patterns of alcoholic couples. These are important studies because communication is a readily observable interaction and it can give information about the quality of the relationship from verbal and nonverbal levels. Within a marriage communication functions, first, to share information and to co-ordinate the couple's interaction, particularly in the areas of childcare, financial and household management. Problem-solving skills are essential and if they break down coercion and power struggles are likely to develop. Second, communication is closely involved in the establishing and enhancing of a close intimate bond between partners. The ability to speak honestly and directly, to share one's feelings, to tell clearly of one's appreciation of what is satisfying and pleasing are all important behaviours.

Hanson, Sands, & Sheldon (1968) looked at the communication of problem drinkers and their wives and made a tentative observation that the messages sent by problem drinkers to their wives tended to be indirect and lacking in clarity,

so that their wives had difficulty understanding them. Gorad (1971) and Kennedy (1976) investigated the nature of the interaction of spouses in simulation game situations. Couples from alcohol-complicated marriages were compared with those from 'normal' marriages. Gorad reported that the interactional style of alcoholic couples was more competitive, each partner seemed to be in a struggle for a 'one-up' position, and there was less co-operation. Also he noted that the communication of the problem drinker was characteristically more responsibility-avoiding than wives or control subjects. Kennedy did not, as he had anticipated find a "distinct" game style. Alcoholic couples instead, displayed both competitive and co-operative styles. Generally he found that their game and communication measures were more similar to those of normal couples rather than to couples in which one spouse suffered from a psychiatric problem. He concluded, "Although alcoholic couples did not show a homeogeneous style of (sic) game interaction, they did show more ineffective or distorted communication, rigidity and extremeness in their interaction relative to other groups". (Kennedy, 1976, p.32).

Hersen et al (1973) reported, from observations in a laboratory setting, that wives of problem drinkers gave their husbands significantly more differential attention than in psychiatric couples and proposed that this may serve to reinforce their husband's alcohol abuse. Becker and Miller (1976) did a similar study but found no significant differences between alcoholic or psychiatric couples on six out of seven dependent measures. However, they reported that the communication of alcoholic couples as a group consisted of more interruptions than the psychiatric control group. These last two studies unfortunately have the weakness that

alcoholic couples were not compared to a control group of normal marriages.

Steinglass used behavioural observation (1) of alcoholic couples in a hospital setting (1977) and (11) of families in their home environment (1981). Instead of the drinking of problem-drinkers leading to negative consequences such as violence, instability and interference of personal interactions, he found that their drinking often had adaptive consequences for family stability and functioning. For some couples, drinking allowed them to display their affection more freely and to permit sexual activity. In others, it offered a temporary solution to repetitive and chronic problems such as depression. These consequences, he proposed, were sufficiently reinforcing to maintain the drinking. More recently he has described couples in alcohol-complicated marriages as being more restricted and less flexible in their interactions than non-alcoholic couples. Their interactions were least flexible when the problem drinker was actively drinking. Orford, Oppenheimer, Egert, Hensman & Guthrie (1976) in a correlational study investigated the relationship between marital cohesion and such indices as economic status and personal esteem. He found that couples which reported (a) mutual affection (b) husband involvement in family tasks, (c) favourable spouse perceptions and (d) optimism about the future of the marriage had a favourable out-come to their marriage. Therefore, cognitive factors are also seen to be important in the prognosis of alcohol-complicated marriages.

> In summary then, "(These) studies have (sic) demonstrated differences between alcoholic couples and non-alcoholic controls along the dimensions of communication skills, problem-solving abilities, effective

attachments, and marital cohesiveness. These differences demonstrate the multi-problem status of the alcoholic marriage. The individual partners are confused about their roles. They have little concept of one another's needs and as a working pair, are unable to arrive at a consensus. The result is a rigid marriage" (Wolin, 1982). Suprisingly perhaps, this description could depict other distressed marriages, unaffected by alcohol problems.

Right from BMT'S beginnings with Stuart (1969) it has proposed that marital satisfaction is a function of spouse-emitted reinforcers and punishers. The spouse is viewed as potentially the most salient member of a couple's social environment. He/she provides consistent positive reinforcement in the form of affection and companionship, verbal and sexual communication and emotional and economic support. In the case of distressed marriages, he/she is a major source of coercion and aversive interaction. Ongoing marital problems are therefore maintained by a lack of positive reinforcement and/or a high incidence of punishment and avoidance tactics (coercion).

The causality of behaviour within a relationship is seen as interdependent, so that what one partner does consequentially influences the subsequent actions of the other spouse. This is called reciprocity (Patterson & Reid, 1970), and assumes that spouses reinforce or punish each other at equivalent rates. Furthermore, distressed couples have been found to be more sensitive to the aversive actions from their partners and more likely to reciprocate negative behaviour, than non-distressed counterparts (Gottman, Markman & Notarius, 1977; Jacobson, Waldron & Moore, 1980).

For reviews of behavioural theories of marriage see Weiss (1978) and, Jacobson & Margolin (1979). BMT nowadays emphasises: (1) the reciprocal exchange of rewards and punishers in maintaining each partner's behaviour, (2) the importance of pinpointing desired changes in behavioural terms, (3) development of adaptive communication skills, (4) problem specification and negotiation of possible solutions, (5) and the use of behavioural contracts (Haye & Blampied, 1982).

It is too simplistic to identify the problem drinking of one or both partners as the source of all the distress in an alcohol-complicated marriage. This approach would suggest that once the drinking stops or is under control then the relationship will function well again. Unfortunately, this is often not the case. Behavioural theory acknowledges that behaviours are learned through the process of repetition over time. The family's interaction may be immediately affected by alcoholic drinking, yet in the long term, maladaptive forms of communication, relating and coping with stress develop and endure. By removing only the problem-drinking other rigid and problematic forms of interaction may not change.

BMT tries to encourage couples to see the strengths and positive aspects of each other and to shift their attention from being almost exclusively negatively focused. The therapy uses already existing positive reinforcement, teaching each partner to identify the pleasurable behaviours (pleases) received from his/her spouse. By teaching learning principles such as reinforcement, punishment and extinction, it helps couples to use positive control tactics as a means of altering one another's behaviours, in an attempt to reverse coercive patterns of interaction. Spouses, in accepting the

concept of reciprocity, are encouraged to take joint responsibility to change and maintain any improvements in the relationship after therapy.

BMT also tackles the process of communication. Much of the initial therapy involves the teaching and practice of listening skills. Couples are encouraged to be clear and direct about what they say and to be able to talk about their feelings. An ultimate goal of communication training is problem-solving. Couples are first taught to "pinpoint", so that problems are defined clearly and objectively. During the process of discussing a problem they are further taught to consider as many solutions as possible and choose a mutually agreed-upon one (compromising if need be). The use of contracts is taught because they help to make agreements permanent and clear, especially if they describe the contingencies surrounding certain behaviours.

By building communication skills into the behavioural repertoire of an alcohol affected couple, BMT prepares them to function on a more intimate emotional level. A couple is enabled to maintain a mutually satisfying relationship and to potentially deal with problems as they arise, through the use of their knowledge of behaviour control principles and problem solving skills. After therapy couples should have more flexibility both in their social relationships and their personal communication.

The author would like to emphasise, however, Orford's (1975, 1979) caution not to over simplify the area of marriage and alcohol, so as to assume that marital difficulties suffered by all alcohol-complicated marriages are a special case that differ greatly from other problem marriages.

"(First), Alcohol dependence is far from being a fixed

> entity which takes on invariant form, and it is not surprising to find that family patterns associated with it are highly varied. There may be general trends but there are no simple generalisations. Secondly, there is no reason to suppose that the findings on marriage roles are peculiar to alcohol problems. Studies of families in which husbands had quite different forms of psychological distress have produced very similar results" (Orford, 1979, p.79).

Finally, the development of our understanding of alcohol-complicated marriages must be intergrated into the wider socio-psychological theories for marriage as well as for alcohol abuse. Marriage, for instance, is known to progress through various developmental stages, which influence the precise nature of marital satisfaction at any time.

METHOD

"BMT tries to encourage couples to see the strengths and positive aspects of each other and shift their attention from being almost exclusively negatively focused" (p.10).

SUBJECTS

Subjects were recruited through the Alcohol Counselling Centre (Christchurch), where they had been receiving prior assessment and/or treatment. Before treatment proceeded, couples were assessed and had to meet the selection criteria.

Selection Criteria

(1) Cohabitation: the couples had to be living together.

(2) MAT Scores below 200: the couple's combined scores of the Marital Adjustment Test (MAT), Locke & Wallace (1959) had to be below 200 points. This has been used widely as indicative of a distressed marriage.

(3) Alcohol Affected: At least one of the couples must have had an alcohol problem and been assessed and/or treated for it within the last three years, by a recognised treatment agency.

(4) No Obvious Psychiatric Problems: i.e. severe depression or schizophrenia.

(5) Signed Consent: Following the initial assessment, consent was obtained by the couples and therapists signing the 'Marriage Therapy Contract' after its terms had been discussed.

Subject Description

Altogether, 9 couples inquired about undertaking the course. Four dropped out after the initial interview and one other couple was rejected because their MAT score was above the selection criterion.

Couple A Both partners were 26 years old and had been married for 4 years 9 months at the time of treatment. They had three small children. The husband had had three years education at University and was working in a dairy factory, earning around $20,000 p.a. The wife was a home-maker although she also did some part-time contract work at home. They had received no pre-marital counselling.

The husband came from a family where his father was an 'alcoholic'. He began drinking at 14 years and felt that he was a problem-drinker when he married. His drinking interferred with his University studies and financial management within the marriage. He unsuccessfully tried to stop drinking in 1981, at which point he began to attend A.A. The following year his wife joined an Al-Anon group, and was encouraged to undertake the Queen Mary Hospital programme as a family member. On her return in November 1982, the couple began attending a marriage group at the Alcohol Counselling Centre. The husband was able to successfully stop drinking in 1983. They were attracted to the course, as they were seeking to improve their communication. There were no major stresses reported during treatment. However, the husband began a part-time course at University at the same time as treatment. Treatment began February 1984.

Couple B Couple B had been married for 4 years and 6 months when they began the course. They had a daughter aged 12 months. Both had had 4 years of secondary education. The

husband was 31 years old and was initially employed as a tax-consultant. His wife was a nurse, and was 27 years old. Their joint income was over $20,000 p.a. Their parish priest had taken some pre-marriage discussions with them. The husband had drunk heavily and experimented with drugs after leaving high school. He had had a variety of employment before he was married. Early in 1983 he attended and 8 week programme at Queen Mary Hospital, where he was described as being in their "middle dependency" category. The same year he began attending the Alcohol Counselling Centre for individual counselling. Also they both attended the Married Couples Group there from which they were referred to the research course. Although the husband was particularly interested in doing the course, his wife was less motivated as she had learned about communication and behaviour modification as part of her professional training. Treatment began August 1983.

Couple C Couple C had been married for 6 years and 7 months at the time of referral. The husband, aged 35, was employed as a radio technician, and the wife aged 26, was a home-maker and worked part-time for the same company. They had one child aged 5 and had a family income of around $20,000. The wife came from a single-parent home, and they had both attended a pre-marriage course at the Campbell Centre. Earlier in 1983 they went to the Marriage Guidance Centre seeking a separation, at which point the husband was asked to go to the Alcohol Counselling Centre to be assessed for his drinking. He showed no signs of physical dependence, and personally did not see his consumption as being excessive. The average weekly amount of money he reportly spent on alcohol was about $20. While he chose not to alter his drinking, he did consent to joint counselling at the Alcohol

Table 2: Summary of Subject Description

Couple	Years married	No. children	Total income	Pre-Marriage Counselling	Previous marital counselling/therapy		MAST Scores	Previous alcohol counselling/therapy
A	4yrs.9m	3	$20,000 p.a.		Married Couples Group (ACC)	Husband*	32	
						Wife	24	Family Members Programme (QMH)
B	4yrs.6m	1	$20,000 p.a.	Parish Priest	Married Couples Group (ACC)	Husband*	40	QMH & ACC
						Wife	7	
C	6yrs.7m	1	$20,000 p.a.	Campbell Centre	Marriage Guidance Centre	Husband*	12	ACC
						Wife	2	
D	16yrs	3	$20,000 p.a.		Married Couples Group	Husband*	35	QMH
						Wife*	39	QMH

Note: ACC = Alcohol Counselling Centre, Christchurch; QMH = Queen Mary Hospital, Hanmer;

* Problem Drinker.

Counselling Centre. They subsequently entered the research programme. Treatment began June 1983.

Couple D Both husband and wife were 38 years of age. They had been married for 16 years and had 3 children. Both said that they believed that their parents did not have happy marriages. The husband had two years of secondary education before joining the army. The wife had 3 years of secondary education and worked as a home aid. Their family income was over $20,000 p.a. Both partners had had treatment for alcoholism at Queen Mary Hospital during 1982 where their alcoholism was described as in the "middle dependency" category. They also attended the Married Couples Group at the Alcohol Counselling Centre and A.A.

The husband suffered a stroke at the beginning of 1983 and was subsequently impotent. Treatment began in August 1983. The Army transferred the husband to the North Island at the end of the year therefore some follow-up data was not obtained for them.

SETTING

Pre-treatment and follow-up assessment of couples was conducted at the Alcohol Counselling Centre, where treatment for Couple C was also held. Treatment for Couples A, B and D occurred at the Psychology Department of the University of Canterbury.

Couples B and D met as a Group. The other two Couples were seen conjointly.

METHODOLOGY

The assessment battery is described in Table 3.

MAT

The MAT is a well established self-report index of

Table 3: Assessment Battery

Instrument	Abbreviation	Scores	Validation & Treatment Data	Administered	References
Marital Adjustment Test	MAT	Range: 0-158 (individual score) Criteria Distressed Couple: 200 Nondistressed Couple: 200 (joint score)	Distressed: *[1] $\bar{X}$=129.8 (24.8) Nondistressed: $\bar{X}$=252.3 (13.1) Pre-treatment: $\bar{X}$=126.8 Post-treatment: $\bar{X}$=183.2	Pre-therapy Post-therapy Follow-up	Locke & Wallace, 1959 *[1] Blampied et al. 1983
Marital Happiness Scale	MHS	Range: 10-100 (individual score) Low scores indicate marital distress	(Pre-therapy) *[2] Control Counselling Phase: $\bar{X}$=54.8 (Approx) Reciprocity Counselling Phase: $\bar{X}$=72.9 (Approx)	Pre-therapy Therapy (Weekly) Post-therapy Follow-up	Azrin, Naster & Jones, 1973 *[2]Estimated from Fig. s 2 & 3, Azrin et al, 1973

Instrument	Abbreviation	Scores	Validation & Treatment Data	Administered	References
Areas of Change Questionnaire	ACQ	Range: 0-78 (Couple's Score) High Score indicate marital distress	Distress: *3 $\bar{X}$=27.5 (9.5) Nondistressed: $\bar{X}$= 4.0 (4.3) Pre-treatment: $\bar{X}$=25.9 Post-treatment: $\bar{X}$=12.1	Pre-therapy Post-therapy Follow-up	Patterson, 1976 *3 Blampied et al, 1983
Spouse Observation Checklist	SOC	Frequency of: (1) Pleases/day (11) Displeases/day	Pre & Post Baseline ranges: *4 Total Pleases/day = 30.0-27.4 Total Displeases/day = 1.8-2.1	Pre-therapy Post-therapy Follow-up	Patterson, 1976 Will, Weiss, & Patterson 1974 *4Stein, Girodo & Dotzenroth, 1982
Inventory of Rewarding Activities	IRA	(1) All activities engaged in with spouse (Act S-R) (11) Proportion of activities with spouse (Prop A)	Distressed *5 $\bar{X}$(Act S-R)=45.1(H) =44.2(W) $\bar{X}$(Prop A) =0.88(H) =0.71(W) Nondistressed: $\bar{X}$(Act S-R)=77.5(H) =72.9(W) $\bar{X}$(Prop A) =0.99(H) =0.99(W)	Pre-therapy Post-therapy Follow-up	Birchler, 1975 *5 Blampied et al

Instrument	Abbreviation	Scores	Validation & Treatment Data	Administered	References
Estimate of Current Time Distribution	CTD	(1) Rewarding time with spouse (RTS): Hours/ day (11) Proportion of rewarding time with spouse (Prop):Hours/ day	Pre-treatment $\bar{X}$(RTS)=2.62 (H) =2.04 (W) $\bar{X}$(Prop)=0.62(H) =0.50(W) Post-treatment $\bar{X}$(RTS)=3.51 (H) =2.70 (W) $\bar{X}$(Prop)=0.62(H) =0.59(W)	Pre-therapy Post-therapy Follow-up	Blampied, Church & Haye, 1983
Michigan Alcoholism Screening Test (revised*)	MAST	Range: 0-53 Criteria 0-4: Non alcoholic 5-6:Suggestive of alcoholism 7-53: Indicating alcoholism		Pre-therapy	Selzer, 1971 Moore, 1972 *Selzer, Vinokur & Van Rooijen, 1975
Self-rating Depression Scale	SDS	Range: 25-100 High scores indicate distress	Validation [6] general Pop* Age (20-29): $\bar{X}$(M)=30.6(6.6) $\bar{X}$(F)=34.4(6.8) Age (30-39): $\bar{X}$(M)=30.7(6.3) $\bar{X}$(F)=35.3(8.2)	Pre-therapy Post-therapy Follow-up	Zung, 1965 *[6] Knight et al, 1983

(H) = husband; (W) = wife; (M) = male; (F) = female; (No) = Standard deviation.

marital adjustment. It provides a global rating of marital satisfaction for each partner, with an individual score of 100 or below as the criterion for a distressed relationship. For the purposes of analysis, the combined score of the couple was used, so that a combined score of below 200 was used as a selection criterion. However, like any global rating it "is vulnerable to influences other than real changes in the relationship, it also fails to capture the complexity of the relationship or to indicate the most appropriate level of intervention" (Blampied & Haye, 1982. p.1). Neither does it identify areas for change within the marriage.

MHS

This instrument consists of ten 10-point scale items, nine of which inquire into the subject's "happiness" in various dimensions of the marital relationship, and the tenth item identifies the subject's "general happiness" with the marriage.

Outside the original study there has been no psychometric examination of it and very few reported studies using it. (Bornstein, Bach, Heider & Ernst, 1981; Stein et al, 1982; Robinson & Price, 1976). The MHS nevertheless has a high face validity, and is regularly used by counsellors at the Alcohol Counselling Centre, because it provides a quick assessment of the marital relationship and its comprehensive range of marriage-specific activities can give a clear indication of probable areas of distress. It is often re-administered at fortnightly or monthly intervals to give an indication whether there have been changes within the relationship.

Azrin et al (1973) used the scale to provide a day to day index of subject's marital satisfaction, and plotted

weekly means of these scores. However, in the present study the MHS was administered at each session the couples attended, giving a weekly measure during therapy of marital satisfaction, as well as pre - post - and follow-up scores. During its use at the Alcohol Counselling Centre, MHS scores have often been noticed to deteriorate after couples have begun therapy relating to their marriage. One suggestion put forward concerning this is that as couples focused upon their partner's and their orn behaviour they became more aware of the extent of their problems.

ACQ

The ACQ is self report measure in which each spouse is asked to rate on a 7 point scale, the degree of change desired (ranging from "much more" to "much less") in specific behavious covering 34 potential problem areas in the marriage. Inventories from both spouses are scored together to give a measure of the degree of conflict or disagreement that prevails within the relationship. From this a list of discussion topics can be made to give the couple options for discussion exercises, and for use in therapy.

There has been extensive research to show its empirical validity and utility in discriminating between distressed and non-distressed couples. (Birchler & Webb 1977; Birchler et al 1975; Greer & D'Zurilla; 1975; Margolin, 1983; Margolin et al 1975; Weiss et al 1973).

Blampied, Church & Haye, (1983) validated it on a New Zealand sample and found it to be more effective at discriminating the distressed from non-distressed than the MAT.

SOC

The Spouse Observation Checklist is a quasi-observational measure in which both spouses attempt to record the

frequency with which rewarding and displeasing behaviour is exchanged between each other in their home environment. Each partner was asked to record at the end of the day the daily frequency of specific behavious they and their partner did, using a comprehensive checklist of behaviours, along with a judgement as to whether each action was "pleasing" or"displeasing". It was administered for at least one week pre and post-treatment. However, couples found it a time-consumming task to do and only one couple was willing to complete it for follow-up. Also, as a means of saving time, it is most likely that subjects tended not to consult their lists after the first few days and would write down what they remembered to be pleasing and displeasing. This meant that it was more difficult to categorise items, as originally the checklist was divided into 12 areas of marital functioning.

Research (Birchler, Weiss & Vincent 1975; Barnett & Nietzel, 1979; Wills, Weiss & Patterson, 1974) has generally shown that by using mean please to displease ratio the SOC discriminates between distressed and non-distressed couples. However, Jacobson & Moore (1981) found that there was a very low consensus of reported behaviour between spouses, a mean of 24% and 52% for distressed and non-distressed couples respectively. Although when items were classified as inferential and non-inferential, they found that couples agreed more closely on the non-inferential items. Christensen & Nies (1980) also found reliability of the SOC to be very low and negatively correlated with marital happiness.

SDS

The Self-rating Depression Scale is a brief, easily administered scale based on the most commonly found characteristics of depression which had been cited from factor

analytical studies. Some research has also shown a correlation between marital distress and depression. Therefore a depression measure was used to try to quantify any signs of depression and see if they were alleviated after treatment. The scale comprises a list of 20 items of which 2 relate to affect; 8 to biological symptoms and 10 to presence of psychological disturbance. It is constructed so that 10 items are worded systematically positive and 10 systematically negative. The subject is asked to rate each statement on a 4 point scale from "rarely or none of the time" to "most or all of the time" weighted one to four respectively. The raw score is transferred into an SDS Index Score (which is the percentage obtained out of the 80 possible scale points) = $\frac{\text{raw score x 5}}{4}$.

The subjects' SDS Index Scores were compared to New Zealand Norms that were obtained by Knight, Waal-Manning, & Spears (1983). One weakness is that some items of the SDS tap into anxiety although they are only a small proportion of the total items. Therefore the Depression Inventory, Beck (1967) may have given a more specific depression score. Nevertheless it was used because Blampied, Church & Haye (1983) used it and as it gives a global indication of personal distress.

IRA

The Inventory of Rewarding Activity is a checklist of 100 recreational and potentially rewarding activities. Each activity has 5 columns to clarify with whom the subject was participating in the activity with. Each subject is asked to consider the past 4 weeks and mark the appropriate items. The purpose of this inventory was two fold: Firstly, to see the proportion of the activities which included and excluded the spouse, and secondly to see if, after therapy, there was

a change in this level and proportion including the spouse. It was hoped that due to an increased awareness of the need of joint, mutually reinforcing activities, that spouses would engage in more activities together.

CTD

The Current Time Distribution Inventory analyses the use of time during a week. Each day is divided into 4 periods time spent asleep and at rest; time at work; and other time spent doing activities with or without spouse. Each subject was asked to put down the approximate number of hours each day engaged in these types of activities. What was of interest in this study was the proportion of time each day, that each partner spent engaged in rewarding activities with his/her spouse. As with the IRA it was generally hoped that after therapy couples would have increased the number of hours spent in joint activities.

MAST

The Michigan Alcoholic Screening Test was originally developed as a diagnostic instrument. It was used at pre-treatment as an objective measure to help identify the problem drinker and provide some indication of the extent of the problem. The MAST was used because its wording enabled subjects who were abstinent during assessment to give answers relating to a past alcohol problem. This measure was not repeated as alcoholic status of subjects was not expected to change much over treatment.

Marital Grids

The Marital Grid is a repertory grid specifically developed to study changes in a couples satisfaction within their relationship over the course of therapy and at follow-up.

The advantage it has over a traditional measure like the MAT is that one can get an overall picture of how one perceives his/herself compared to their spouse, or any other relevant person.

The repertory grid has its origins in the theory of Personal Constructs (Kelly, 1955). It has been used in various ways to study changes in interpersonal perception in response to therapeutic interventions. Kelly developed and used the repertory grid technique to build a picture of an individuals conceptual system, which he thought of as the cognitive centre where a person's experience of the world and his/her actions were categorised and construed in a meaningful way. A repertory grid was seen by Kelly as a matrix representing perceptual space onto which one can plot a unique system of cross references between personal observations made of the world and personal constructs used.

"A construct is a way in which some things are seen as being alike and yet different from others" (Bannister & Main, 1968). A construct is a bipolar dimension which measures the extent of an attribute of something. People use them as means of making sense of their environment and so anticipating it more fully (eg. light-dark, large-small). Elements are sets of observations which can be mapped out to identify their position along all the constructs. In the basic repertory grid method, the subject compares a number of people (the elements) against a number of descriptions (the constructs). In this case the people and descriptions were supplied by the tester. However, more can be learned if the subject provides individually relevant ones.

Comparisons are obtained by rating or ranking all the elements against all the constructs, and are then subjected

to mathematical analysis. In Slater's principal component analysis of the grid (INGRID 72), the relationships of elements and constructs are also expressed in terms of their loadings upon the principal components. Each element and each construct is located by its loading upon each of these components. By plotting out elements and constructs with regard to the first two principal components (which usually account for about 75% if the total variance of the grid) a simplified map of conceptual space is derived. On this map, elements are located in different regions,and their locations can be described in terms of their proximity to other elements and constructs and the meaning given to each of them.

The Marital Grid was given to each subject in which he/she was to rate satisfaction on a scale of 1 to 10 on 12 areas of the marriage. (The higher the rating the more satisfied). These 12 areas constituted the constructs and were reported by Ariz et al (1973) and used later by Weiss (1978, p. 198-199) as the basis of a behavioural view of a marriage. As interest was primarily in the married couple, 4 out of the 6 elements used related to the subject and his/her spouse. The last two were "the average N.Z. husband" and "the average N.Z. wife" and they were put in to see how they compared themselves to their idea of how average husbands and wives behave. The grid was given before and after therapy and for follow-up. Two-Component maps were constructed to record their perception of the marriage at those particular times.

Reconstruction grids (Ryle & Lipshitz, 1975) were also made to show the change of the subject's perception of spouse and the spouse's perception of subject over time. In this method the serial ratings of those two elements were included into a single grid and formed a graphic representation of

change through time. Finally each individuals grids were compared in pairs using DELTA. From this a general correlation was reported to give some indication of the similarity between subjects perception of the marriage at the different periods. Of course a more comprehensive understanding of what has changed and the magnitude of it can be grasped by interpreting the grid's loadings, elements distants and construct correlations. A short description of each couple's perception, and any changes that occurred following therapy will be given in the Results Section.

Target Behaviours

It was planned to use a multiple baseline strategy in order to change problem behaviours in the marriage. Taking Jacobson's BMT Programme (Jacobson, 1977, 1979) as an example it was intended that during the intake interviews spouses would be helped to identify and define problem behaviours in their partners which could be either accelerated or decelerated, and therefore baseline recording of two target responses for each spouse could begin prior to therapy. However, problem identification and definition was particularly difficult and more time consumming than initially expected. This meant that baseline recording often didn't begin until treatment had started, further shortening intervention periods especially of the second behaviours.

The result was that often only one problem for each subject was dealt with for any reasonable length of time. In retrospect more time could have profitably used for discussion of problem behaviour especially in respect to thei identification and definition in behavioural persepctive than was allocated in the CRESST programme.

Audio-tape Analysis

An already existing communication code for analysing audiotapes was difficult to find. Numerous researchers were written to but only O'Leary kindly replied. Using their code as the main framework it was compared with the communication responses described in the Marital Interaction Coding System (Patterson, 1976) and by Lester, Beckham & Bancom (1980). By eliminating neutral responses, overlapping codes and the non-verbal responses which could not be analysed over audio-recording, a final list of positive and negative communications was derived. The audio-tapes of each couple were transcribed and analysed in terms of negative and positive parts of communication. Once converted into rates, these were compared over pre and post-treatment, and follow-up where possible. A hypothesis to be tested was that training would increase the rate of positive communication and decrease the rate of negative communication.

Transcribing In order to make easier for coding, the discussion was written on alternate lines of a sheet of lined paper and with each change of speaker a new line was begin and the letter "H" (for husband) or "W" (for wife) was written in the margin to denote who was speaking. The unit of analysis was any audible response (either verbal or nonverbal) which conveys new meaning to the discussion either to enhance and facillitate open, clear, honest communication eg "positive responses" or that inhibit and disrupt the communication process eg "negative responses". To aid the coding process an attempt was made during transcribing to use a new line for each comment, nonverbal response or parts of a sentence which conveyed something new to what was just said. Therefore the task in transcribing was not to attempt to create grammatically

complete and correct sentences, but to organise the discussion sequentially in terms of verbal responses. Many neutral non-verbal fillers like "Um...", Mm...m" were left out as they themselves added to new meaning and disrupted the written flow of statements. A short list of notations used in transcribing are as follows:-

(1)	'H'	=	Husband:	Written in margin.
	'W'	=	Wife:	
(2)	'?'	=	Question:	Placed after a verbal response.
(3)	'-'	=	A short pause:	Placed between parts of a statement.
(4)	....	=	A long pause:	Placed between parts of a statement.
(5)	____	=	Interruption:	(i.e. the two people are speaking at once): ruled underneath the words of the principal speaker
(6)	----	=	Incomprehensible speech, either due to mumbling, environmental noise, or poor tape quality: Broken lines are ruled between identifiable words, or on separate lines to denote different utterances.	
(7)	(Laughter)	=	Audible, light-hearted, usually in response to an attempt at humour.	
(8)	(Sigh)	=	Audible, conveying negative feelings or disapproval.	

Coding. First a separate piece of paper was divided up into columns; one for the husband and the other for the wife. Each alternate line of transcript was numbered, then going down the columns each line was likewise numbered; the number being written sequentially in the column deplicting the person speaking.

Secondly, each line was analysed according to the list of 20 categories (See Appendix F). For the responses which

did not fit any category, when the same content was being repeated; or nothing new is being added; a blank was left. When this was accomplished each code was given a "+" (positive) or "-" (negative) beside it depending upon whether it was a positive or negative communication.

Finally these positive and negative responses were totalled for each partner and a joint total was made. The totals were divided by the duration of the taped discussion (in minutes). These response rates could then be plotted on a graph across discussion sessions.

PROCEEDURE

Therapists

The author served as a therapist for all the couples, and saw them individually during the pre, post-treatment and follow-up assessments. However, during the treatment phase the author was helped by Mary Shanahan, a psychology graduate student and counsellor at the Alcohol Counselling Centre.

Pre-treatment

In most cases couples completed a MAT before coming to pre-treatment assessment in order to make sure that they meet the selection criterion of a joint score below 200. On a few occassions, where this was inconvenient, the MAT was a part of the assessment measures given at the initial interviews. These measures included MHS; ACQ; IRA; CTD; MAST; and SDS. The pre-treatment assessment was usually completed in a two hour session or during two shorter sessions, depending upon what was convenient for the subjects. Couple C was seen on 5 occassions before therapy because when they were initially interviewed they were separated and the wife was experiencing a marked depression, which was dealt with first. Once the

assessment battery had been completed, some background information regarding the couple's history was taken with the aid of a short questionnaire. The couple then received a brief explanation of the treatment programme, covering what it consisted of, the committment involved as to homework and exercises, confidentiality, and participation in research. This ended with a treatment contract specifying the tasks required by both client and therapist being signed by all. An exercise was then undertaken to assess the couple's communication style and problem solving skills. Couples B, C and D were given the following instructions: "Choose and discuss an important issue or problem in your marriage and try to reach some agreements upon it". After a short period to consider it, they spent 10 minutes of discussion which was audio-taped. Couple A did Guerney's Communication exercise for assessment instead (Guerney, 1977, See Appendix D). Finally the SOC was explained to them and they were assigned as homework for at least 7 consecutive days on which to complete an SOC. This gave an idea of rate of positive reinforcement and aversive interaction within the marriage prior to therapy.

Treatment

The treatment followed the first eight sessions of Haye's Canterbury Relationship Enrichment & Social Skills Training (CRESST) Programme (Haye, 1983) closely. There were a number of additional exercises and handouts added to this which were considered helpful by the author. (See Appendices B&C) The rationale behind not dealing with sessions 9 and 10 were two-fold. First the author did not feel competent to deal with the sexual difficulties of the marriage and if there were any pertinent problems, as with Couple D, they were referred

to a sex therapist. Secondly, in this study the aim was narrowed down to see how effective the teaching of purely problem-solving skills and behaviour change techniques were on marital distress with this client population.

Each session began with each subject filling in an MHS for the past week. The previous week's homework was handed in and discussed, and each client was asked to share two or three pleases which they had experienced from their spouse over the previous week. Once this was completed, the discussion and exercises followed the CRESST programme. The Treatment phase for couples B, C and D consisted of 10 sessions. This enabled the therapy to go at the pace of the clients, and meant that there was more opportunity for revision and extra practice of parts that couples found difficult to learn. However, owing to a limited time to complete the research the last couples' treatment phase consisted of eight sessions. Another consideration was that the earlier clients commented that ten weeks was very long and this was thought to limit their motivation during the later stages of the course. After the first hour a coffee break was held, which seemed an important measure to help the couples to relax and to help them maintain their level of concentration.

Near the end of each session each couple undertook a 5 minute taped discussion in which they were asked to consider the past week and discuss any problem that arose, trying to use any skills already covered. This gave couples an opportunity to try to deal with any salient problems and also gave an idea of progress during therapy. Finally homework was given for the next week and any remaining questions they had were dealt with. From session 2, homework included discussion exercises and spouse-observation of target behaviours.

Outline of Treatment

(Based upon Sessions 1 to 8 of CRESST, Haye, 1983)

Session One : Introduction to pleases.
Discussion of importance of acknowledging pleases.
Roleplay acknowledging pleases.

Session Two : Introduction into the parts of good communication.
Roleplay sending and receiving simple messages.
Introduction to pin-pointing.
Discussion of problem areas with the marriage.
Choose target behaviours to keep track of.

Session Three : Introduction to nonverbal communication and feelings.
Exercise in nonverbal cues (Based on page 98-99 of Liberman, Wheeler, de Visser, Kuehnel & Kuehnel, 1980).
Practice of listening skills.
Discussion of unconstructive communication.

Session Four : Discussion "The Principles of Human Behaviour".
Watch vignettes from the film "Who Did What To Whom"and discuss which principles were in action.
Discuss how the recording of target behaviours are proceeding. Identify new problem behaviours.
Introduction to 'Asking for Pleases'.

Session Five : Review 'Rewarding, Punishing and Ignoring'
Discussion of habituation, modeling and shaping.

Introduction to coercion and negative spirals.
Finalise Contract for intervention of target behaviours.
Exercise in listening and levelling

Session Six : Review behaviour change techniques.
Discuss 'Passive, Assertive and Aggressive Behaviour'.
Practice the expressing of negative feelings.

Session Seven : Review negative feelings.
Discuss empathy.
Exercise in empathy - role reversal.
Discuss how to cope with change in the marriage.
Role-play - expressing feelings about a change situation.

Session Eight : Discuss 'Workshop Concepts'.
Introduction to leisure time in marriage.
Exercise: both partners discuss improvements to their leisure time.
Exercise: couples make contracts for other target behaviours.

Session Nine : Review of contracting.
Review 'Workshop Concepts'
Discuss how to deal with children.

Session Ten : Revision of course, answer any questions.
Discuss the positive changes in the marriage and ways to maintain them.
Discuss Cookie Jar and Love day exercises
(Adapted from Chapter 2 of Montgomery & Evan, 1

Post-Treatment

Post-Treatment was done a week after the last treatment session. Clients were seen individually for this session. It began with them filling in an MHS, then the assessment battery was re-administered, minus the MAST. A discussion of what had been covered in therapy and how the clients felt they had gone was then had. Any unfinished business, such as problems that were unresolved or behavioural contracts that needed to be re-negotiated was completed. Finally a 10 minute discussion exercise following the same instructions that were given during pre-treatment assessment was recorded. They were issued with a week's supply of SOC's and asked to fill them in as was done for pre-treatment assessment.

Follow-Up

A one month follow-up assessment was chosen due to the limited time there was to complete the Master's thesis, however, a 6 month follow-up or longer would have been desirable. Follow-up tried to replicate post-treatment as closely as possible.

RESULTS

"Much of the initial therapy involves the teaching and practice of listening skills" (p.11).

MAT

There was generally an increase in the joint MAT scores overtime in the expected direction. Except for Couple A whose score was slightly lower at post-treatment this trend was uniform. An interesting phenomenon shown by Couples B and D, who had an extra pre-treatment probe 1 month before treatment, was that their joint MAT scores increased over the month before treatment. They also showed a slight drop at 1 month following treatment, opposite to the changes in Couples A and C. At the pre-treatment phase Couples A, B and D were within 1-2 standard deviations of the expected mean for distressed couples, (Blampied, Haye & Church, 1983), while Couples C's score was 2 standard deviations below the expected mean, suggesting profound marital distress. By post-treatment the scores of Couples B and D had reached the 200 point criterion used in this study to define distressed and non-distressed couples. The magnitude of the increase for Couples B, C and D was between 2 and 3 standard deviations. At follow-up, Couple C further increased about 2 standard deviations while Couple A made a dramatic jump of over 3 standard deviations. Although 3 couples reached the 200 point level, at 1 month follow-up, none had reached the expected mean for the non-distressed

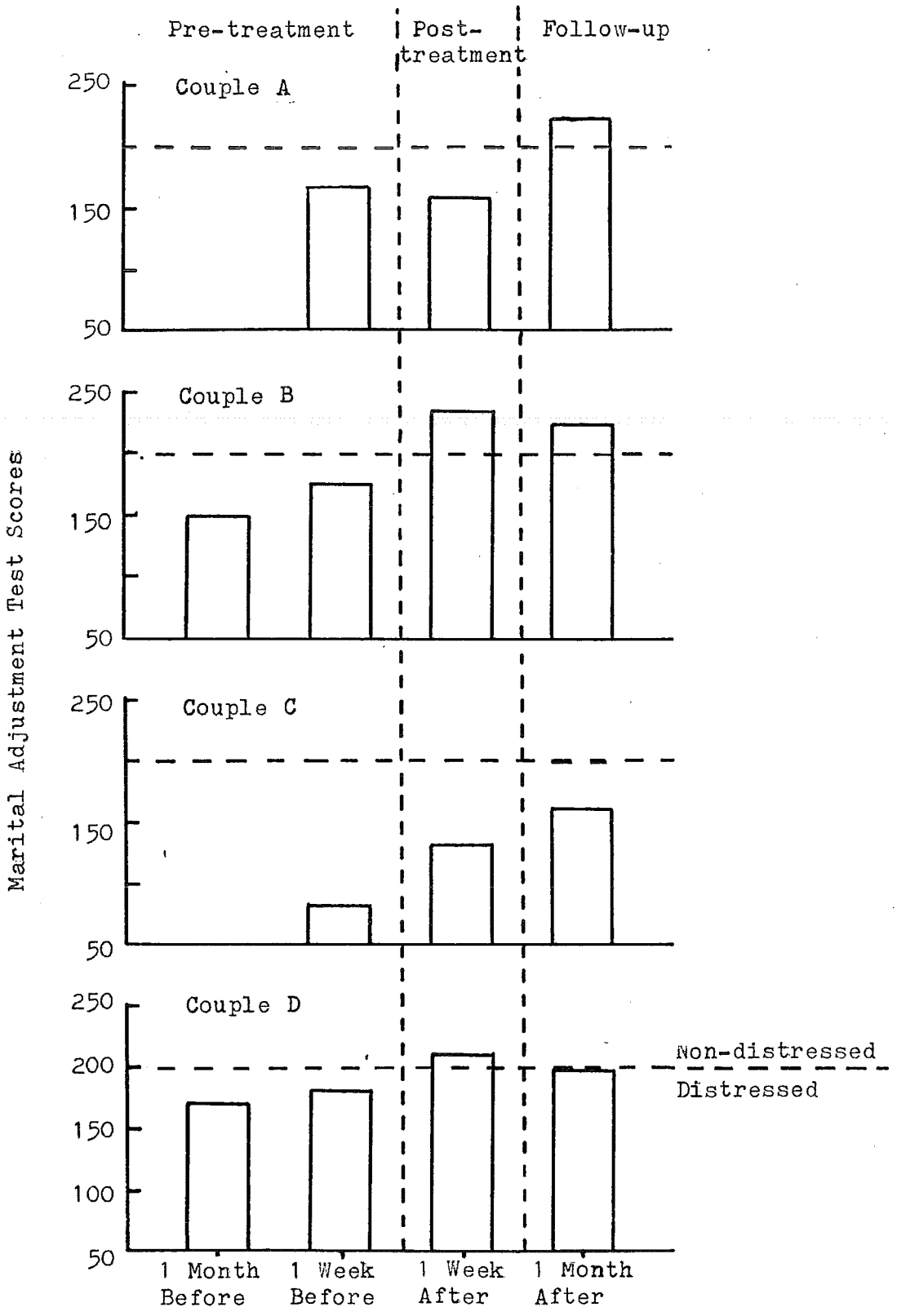


Fig 1 Marital Adjustment Test (MAT) results

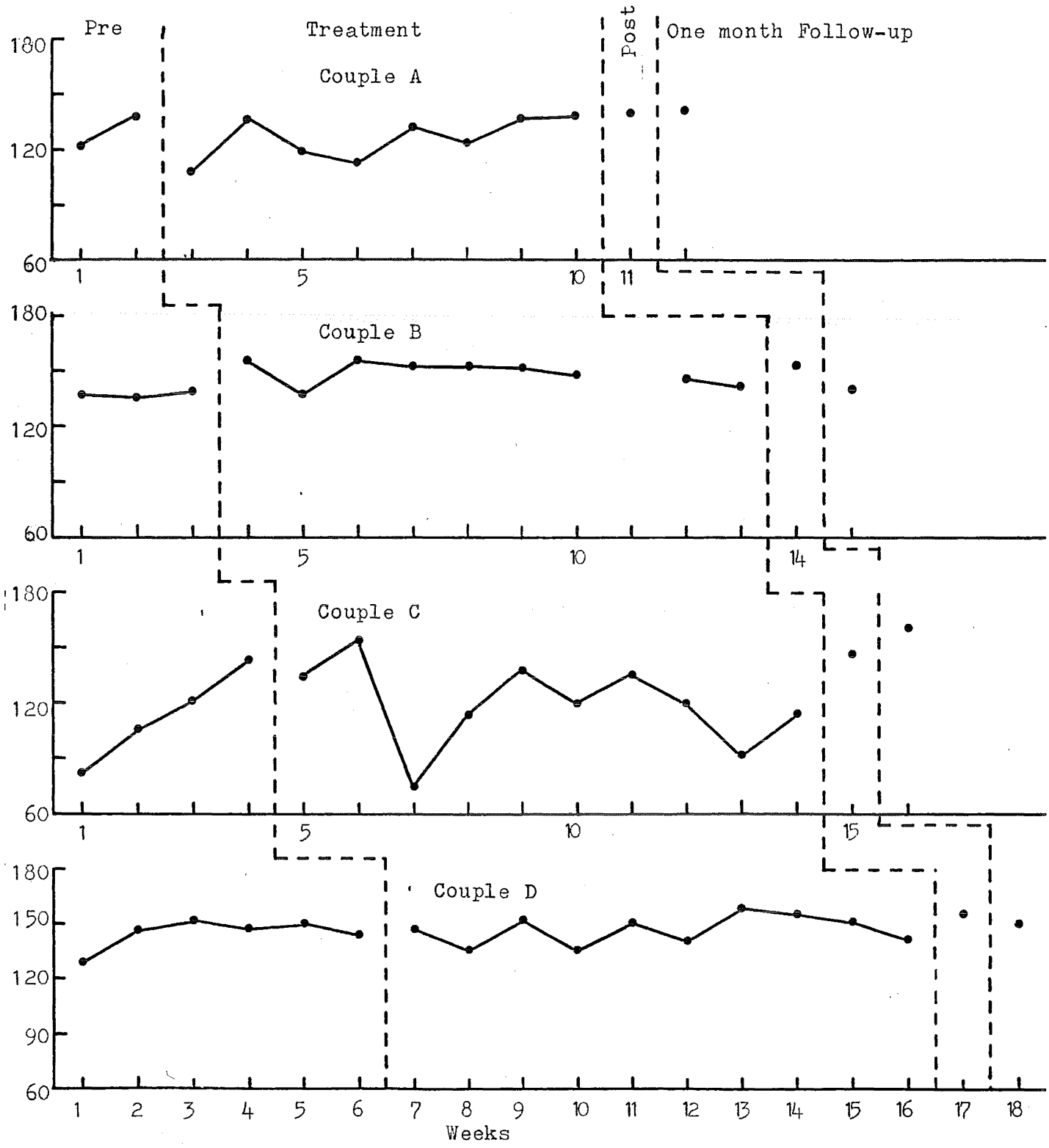


Fig 2 Marital Happiness Scale (MHS) results

group from Blampied et al's (1983) validation study ($\bar{X}$=252.3). Couples A and B fell within 2 standard deviations below this mean while Couple C and D were 1½ and 3 standard deviations above the mean for the distressed group respectively, at follow-up. A possible explanation for this may be that MAT scores increased gradually once couples began to be seen by a counsellor regardless of treatment. Disregarding the slight gains at post-treatment this accounts for the near uniform step-wise increase for Couples B and C from the first pre-treatment MAT score until follow-up for Couples B, C and D.

MHS

During the pre-treatment phase three couples showed an increase in joint MHS score, while Couple B's score remained stable. A notable characteristic during the treatment phase was the variability of the scores particularly for Couples A and C. Treatment scores did not generally increase substantially above what they reached during pre-treatment. The first half of treatment produced the most fluctuation in scores. The mean scores for the first half of treatment for Couples B, C and D differed from the second half of treatment by only 6-7 points and their scores showed a slight drop during the last phase of treatment. Couple A on the other hand made slight gains near the end of treatment. Post-treatment and follow-up scores remained reasonably stable for Couples A, B and D differing little from the upper pre-treatment or treatment scores. Couple C's follow-up score however, increased by 14 points from post-treatment.

ACQ

The pre-treatment ACQ scores for all couples indicated some distress. Couples A, C and D had scores which fell within

Table 4 Areas of Change Questionnaire data.

Couple	Pre-treatment	Post-treatment	Follow-up
A	18	4	1
B	8	12	5
C	23	16	0
D	23	10	*

* Couple moved to North Island.

Table 5 Estimates of Current Time Distribution (CTD) data

Couple		Pre-treatment		Post-treatment		Follow-up	
		h	w	h	w	h	w
A	RTS	4.00	6.57	4.57	5.14	2.71	4.86
	Prop	0.52	0.51	0.52	0.40	0.53	0.67
B	RTS	2.29	0.29	3.43	1.86	3.14	1.14
	Prop	0.37	0.06	0.52	0.93	0.47	0.44
C	RTS	3.43	1.00	2.43	1.00	3.43	5.00
	Prop	0.75	0.19	0.46	0.54	0.50	0.67
D	RTS	2.86	3.14	2.43	0.87	*	
	Prop	0.37	0.58	0.49	0.38		

h = husband, w = wife,; RTS = Rewarding time with spouse

Prop = Proportion of rewarding time with spouse

* Couple moved to North Island

Table 6 Inventory of Rewarding Activities (IRA) data.

Couple		Pre-treatment		Post-treatment		Follow-up	
		h	w	h	w	h	w
A	Act S-R	28	46	32	36	37	40
	Prop A	0.52	0.51	0.52	0.40	0.59	0.67
B	Act S-R	22	12	29	11	27	10
	Prop A	0.54	0.40	0.55	0.50	0.52	0.34
C	Act S-R	11	18	33	29	30	30
	Prop A	0.80	0.26	0.45	0.44	0.51	0.54
D	Act S-R	42	47	35	41	*	
	Prop A	0.63	0.63	0.71	0.56		

h = husband, w = wife, Act S-R = Activities engaged in with spouse

Prop A = Proportion of activities engaged in with spouse

* Couple moved to North Island.

1 standard deviation of the mean score for the distressed group in Blampied et al's validation study, the remaining couple's score was 1 standard deviation above the expected mean for the normal group. At post-treatment all the scores closely coincided with the mean score in Blampied et al's experimental group after treatment. There was a further decrease in scores in all couples tested at 1 month follow-up, these final scores falling within the range for Blampied et al's non-distressed couples.

CTD

There were no clear trends from the CTD data. Only Couple A at pre-treatment measure had both partner's hours within the non-distressed range for RTS (hours). Except for the husband's last measure, it remained fairly consistent. At the 1 month follow-up, the wife's score in Couple C increased dramatically to bring both within a non-distressed range.

IRA

As with the CTD, the data from the IRA did not show a consistent trend. All the couples' measures fell within the distressed range of Blampied et al's validation study.

SOC

Pleases

The SOC data for Couples A, C and D showed the husband please rate to be at its highest level during the pre-treatment phase, while the wife's please rate did not generally change much in either pre-treatment or post-treatment phases. The husbands in Couples A and D showed elevated please rates at post-treatment. Couple A also had a slight increase at follow-up. Unfortunately, no other follow-up data was able to

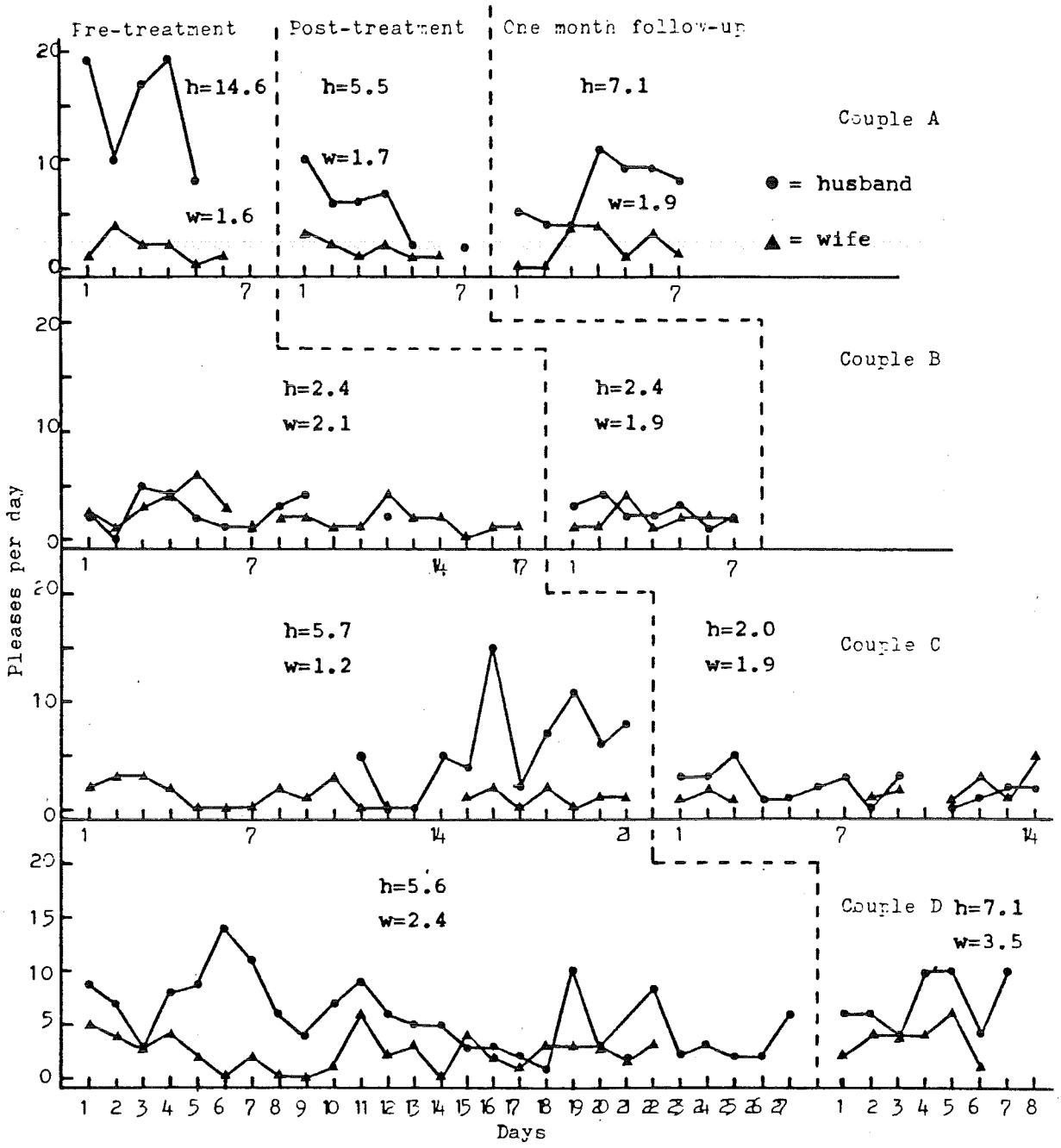


Fig 3 Spouse pleases : SOC

h = mean pleases per day for husband

w = mean pleases per day for wife

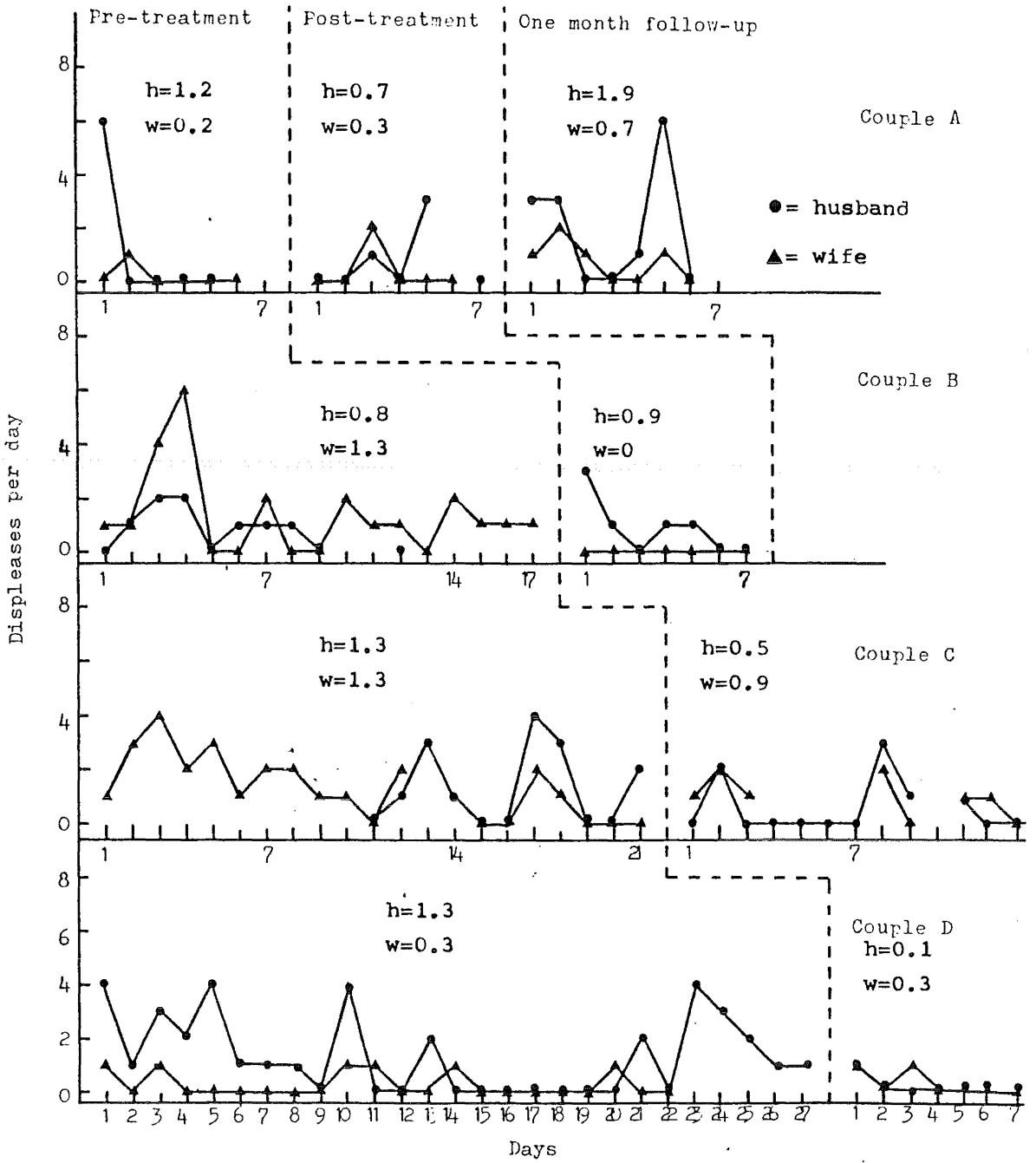


Fig 4 Spouse displeases : SOC

h = mean displeases per day for husband

w = mean displeases per day for wife.

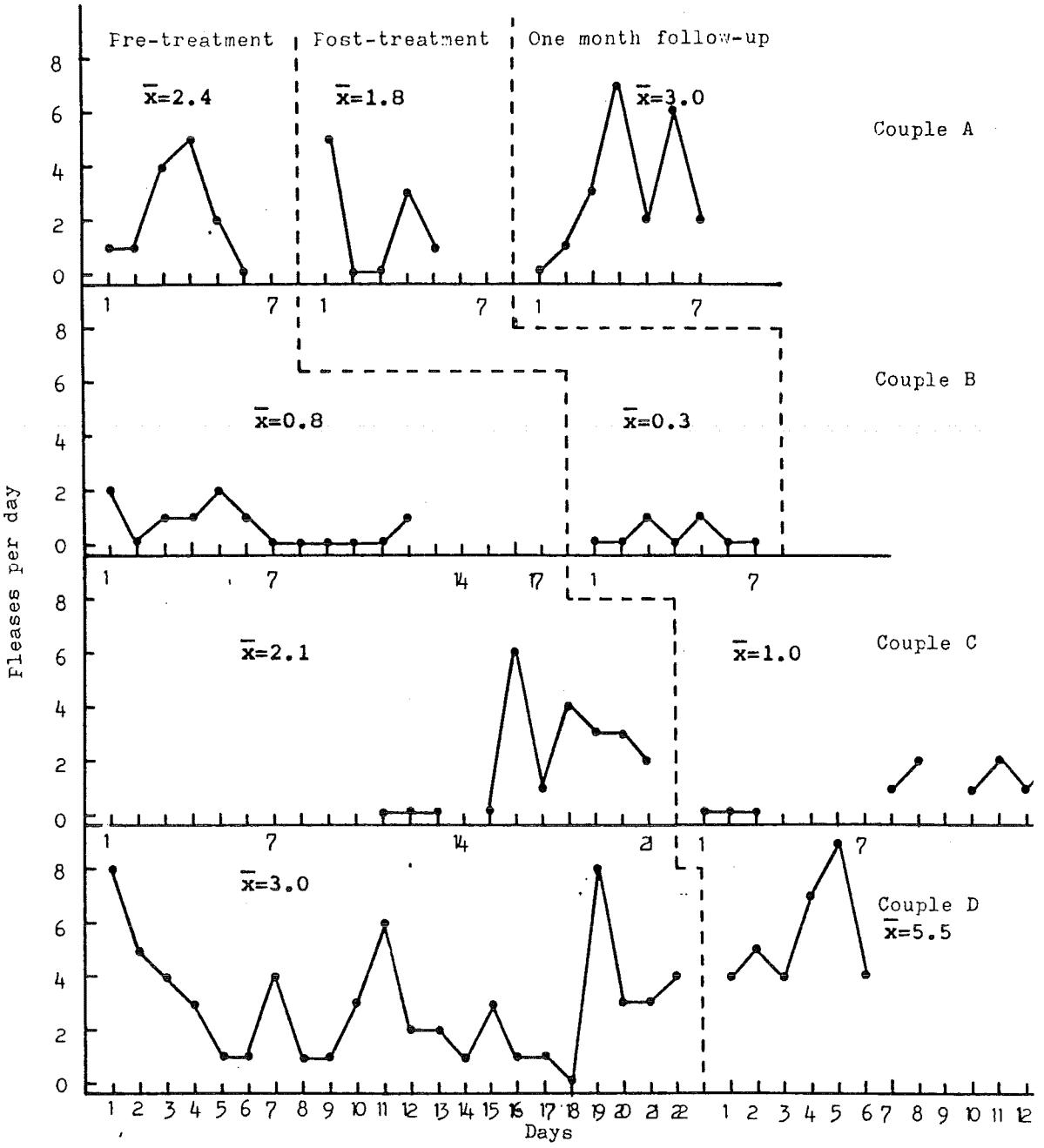


Fig 5 Mutually recorded pleases : SOC

$\bar{x}$ = mean mutual pleases per day

Table 7 Correlation coefficients of Spouse observation, and Self monitoring of pleases.

Couple	Husband-Wife	Husband	Wife
A	0.255	0.365	0.867 (0.001,d.f.16)
B	0.019	0.581 (0.01,d.f.22)	0.126
C	0.022	0.321	0.802 (0.001,d.f.22)
D	0.064	0.494 (0.01,d.f.26)	0.665 (0.001,d.f.36)

(x) = level of significance.

be obtained. There was a tendency for the high levels of the husbands' daily please to decline over time. There was little change in Couple B's please rate at pre and post-treatment.

Displeases

In Couple B, while the husband's post-treatment level of displeases showed no major change compared to pre-treatment, the wife's level showed a marked decline. The opposite trend occurred with Couple C, where the husband's level decreased. In Couple D the wife's displease level was already low and it remained insignificant at post-treatment. Nevertheless the husband's level also decreased significantly. Only Couple A showed an increase in displease level at post-treatment and follow-up. Without having comparable validation data it would be questionable whether any of the couples' displease levels showed evidence of marital distress.

Mutual Pleases

As well as recording spouse observation data Couples were instructed to record their own pleases and displeases. This enabled a comparison to be made of the pleases that were acknowledged as given and received by spouses. When one partner recorded emitting a please, was it recorded as a please by his/her spouse? High levels of jointly recorded pleases would suggest a mutual understanding of what categorises a please for each partner and may be seen as a check on how reliably the couples used the SOC. One would hope that the level of mutual pleases would increase after treatment because couples had opportunity during training to learn about the likes and dislikes of their partner.

The resulting graphs coincided well with the Please data. As with the please data,levels are relatively high at the beginning of pre-treatment and show a decline over that period. Similarly, Couple D showed a marked increase of mutual pleases at post-treatment. Couple A was reasonably high at pre and post-treatment with a slight increase at follow-up.

Correlations

It is interesting to note that the correlations between a subjects' record of own-pleases and spouse-pleases were higher than the correlations between the subject's record of spouse-pleases and their partner's record of own-pleases. This seems to suggest that the SOC is more influenced by the enthusiasm of the observer than a reliable record of the spouse's behaviour.

SDS

Three wives and two husbands had scores on this instrument that indicated some signs of depression before treatment. At post-treatment all client's scores were in the normal range. One month later all the scores remained within normal levels except for the wife of Couple D. Her sudden increase in distress, however, could be associated with the couple's movement to the North Island.

TARGET BEHAVIOURS

Target behaviours were problem behaviours which the couple decided to attempt to change following the behavioural principles discussed during treatment. Although discussion and pin pointing of behavioural problem began right at the beginning of training some couples found this a difficult

Table 8 Self-rating Depression Scale data

Couple		Pre-treatment	Post-treatment	Follow-up
A	h *1	30.0	30.0	26.25
	w *1	40.0	35.0	33.75
B	h *2	30.0	27.5	27.5
	w *1	58.75	30.0	30.0
C	h *2	52.5	27.5	28.75
	w *1	65.0	38.75	35.0
D	h *2	36.25	32.5	32.5
	w *2	36.25	32.5	45.0

h = husband

w = wife

*1 = Age 20-29 years

*2 = Age 30-39 years

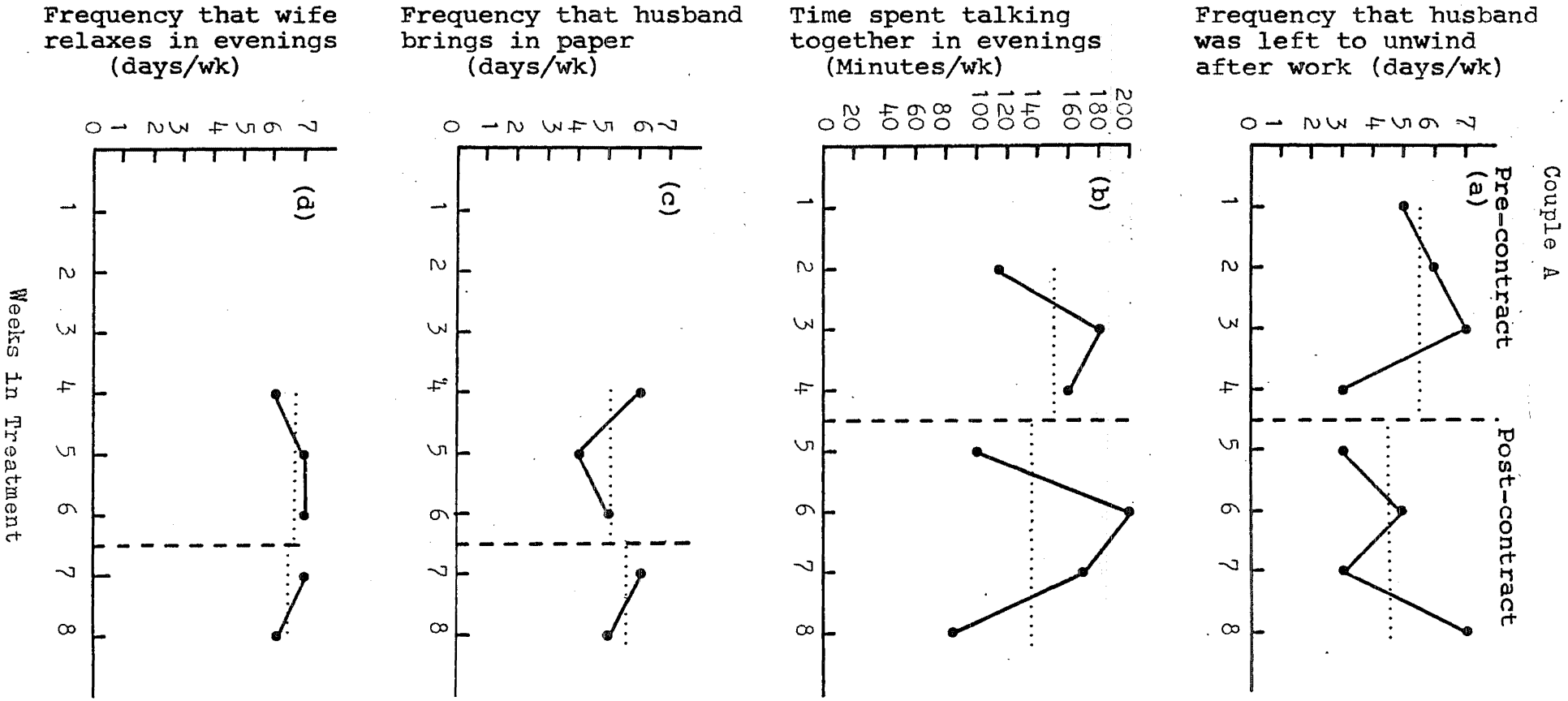


Fig 6 Couple A's target behaviours (pre & post-contract means are marked by dotted lines). 'a) recorded by husband, (b) recorded by wife, (c) recorded by wife, (d) recorded by husband.

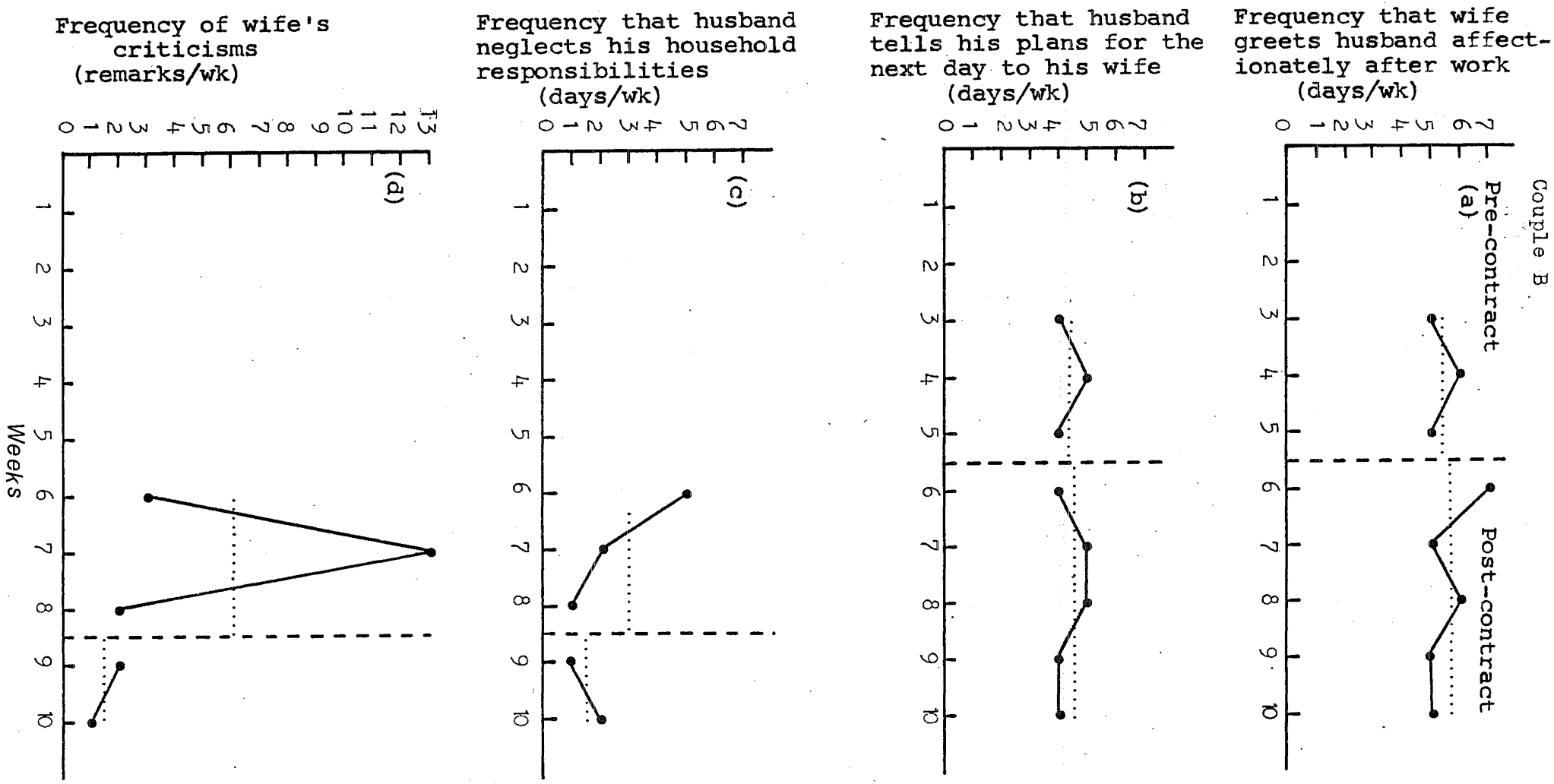


Fig 7 Couple B's target behaviours (a) recorded by husband, (b) recorded by wife, (c) recorded by wife, (d) recorded by husband.

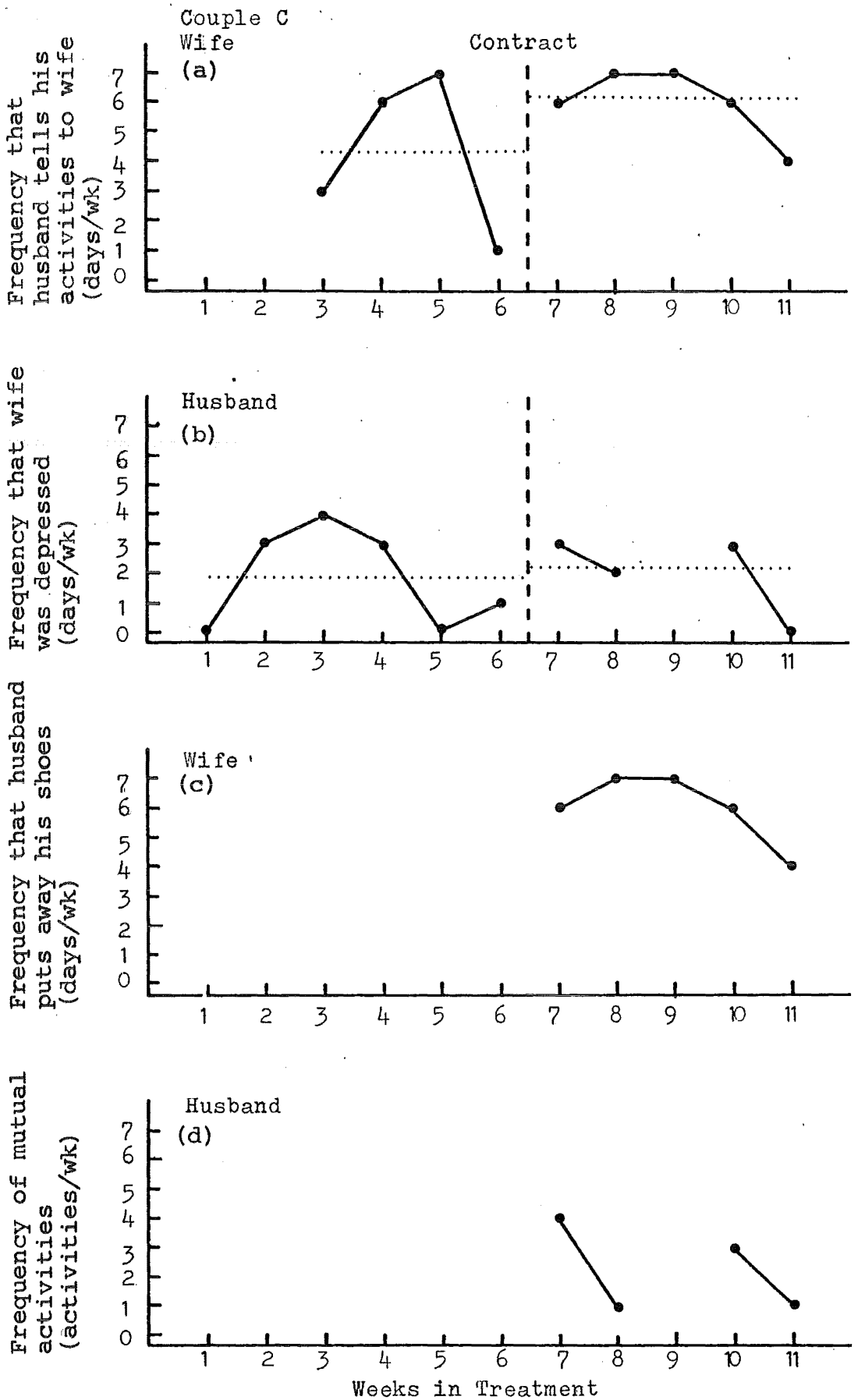


Fig 8 Couple C's target behaviours. (a) recorded by wife, (b) recorded by husband, (c) recorded by wife, (d) recorded by husband.

Table 9 Couple D's target behaviour data.

	Pre-contract				Post-contract			
Week	1	2	3	4	5	6	7	8
(a)	0	3	2	1	0	1	0	1
(b)	1	0	0	0	0	0	0	0

(a) = Weekly frequency of husband ordering and threatening his wife

(b) = Weekly frequency that wife spoke with hand over her mouth

undertaking and took 1 to 2 further weeks to finally identify a behaviour they felt was a problem and were willing to change. The subjects next spent at least 3 weeks collecting baseline data, after which a contract was prepared with the couple, agreeing upon appropriate reinforcement and their contingencies. After that the data continued to be collected while the couple tried to keep to the contract. On the whole the data was variable and in most instances post-contract data was no different from baseline (pre-contract). There were slight changes in Couples B, (graphs c & d) C (graph a) and D. Of these, Couples B and D wished to decrease the frequency of their target behaviours, however, they did so before contracts were made. The mean frequency of weekly discussions were higher than baseline for Couple C. However, frequencies were on the decline at the end of treatment.

AUDIO-TAPE ANALYSIS OF COMMUNICATION

Reliability of Coding

Four transcripts of each couple were coded independently by a technician in the Psychology Department. The transcripts of Couples B, C and D were randomly chosen. This was done to probe the reliability, first to test the utility of the coding system. Secondly, because the author (who was a principal therapist) did the initial coding, the data was open to bias. In the first case, a point-by-point method compared the use of all the communication categories to see how well the sequential data of each observer matched. Wampold and Holloway (1983) have criticised this method as being too stringent, because of

(1) the ambiguity of coding opportunities,

(2) the problem of getting out of synchrony by inserting or

deleting a behaviour, and,

(3) it gives low indexes of agreement that do not adequately convey the similarities of the sequential structure that generally exist between two observers.

Therefore a method based on the number of transitions proposed by them to avoid these problems, was used to analyse the agreement of positive and negative communication.

About 12 hours of training and practice were given to the independent coder, this was approximately one hour of practice to one hour of checking. The mean point-by-point agreement was 59.5%, and ranged from 37.0 to 65.6% and the mean transition co-efficient was r=0.783, and ranged between 0.387 and 0.991. As would be expected there was a low point-by-point agreement. The transition co-efficient, however, was of encouraging magnitude to suggest that with further use and refinement the audio-communication coding system could be a convenient and effective for research and therapy.

Positive Communication

Couple A showed gains in their positive communication, while Couple B showed some increase in their rate near the end of treatment, their post-treatment scores did not differ significantly from pre-treatment. Both spouse's positive communication rates were significantly correlated. In Couple C, there was a gradual increase in the husband's rate until post-treatment. However, the wife's positive communication while often higher than pre-treatment, is variable, and there was little difference between her pre-treatment and post-treatment performance. Unfortunately, there was no post-treatment or follow-up data for Couple D. Both spouses' rates were significantly correlated, but varied quite a bit over treatment. At the end of treatment only the wife's

Table 10 Reliability check statistics of communication analysis

Couple	*	Point-by-point: % Agreement	Positive-negative Communication: Transition Coefficient	N	Significance
A	(1)	42.4	0.655	16	
	(11)	65.6	0.951	6	.01
	(111)	57.1	0.901	4	
	(1V)	49.2	0.971	12	.01
B	(1)	37.0	0.607	16	
	(11)	38.1	0.525	15	
	(111)	50.8	0.387	16	
	(1V)	44.7	0.746	16	.01
C	(1)	46.8	0.784	14	.01
	(11)	56.8	0.991	9	.01
	(111)	52.0	0.612	9	
	(1V)	61.7	0.886	13	.01
D	(1)	49.5	0.814	16	.01
	(11)	58.9	0.925	11	.01
	(111)	54.8	0.891	10	.01
	(1V)	58.9	0.886	9	.01
	Means	51.5	0.783		
			10/16 statistically significant		

* Four transcripts were randomly chosen from each couple.

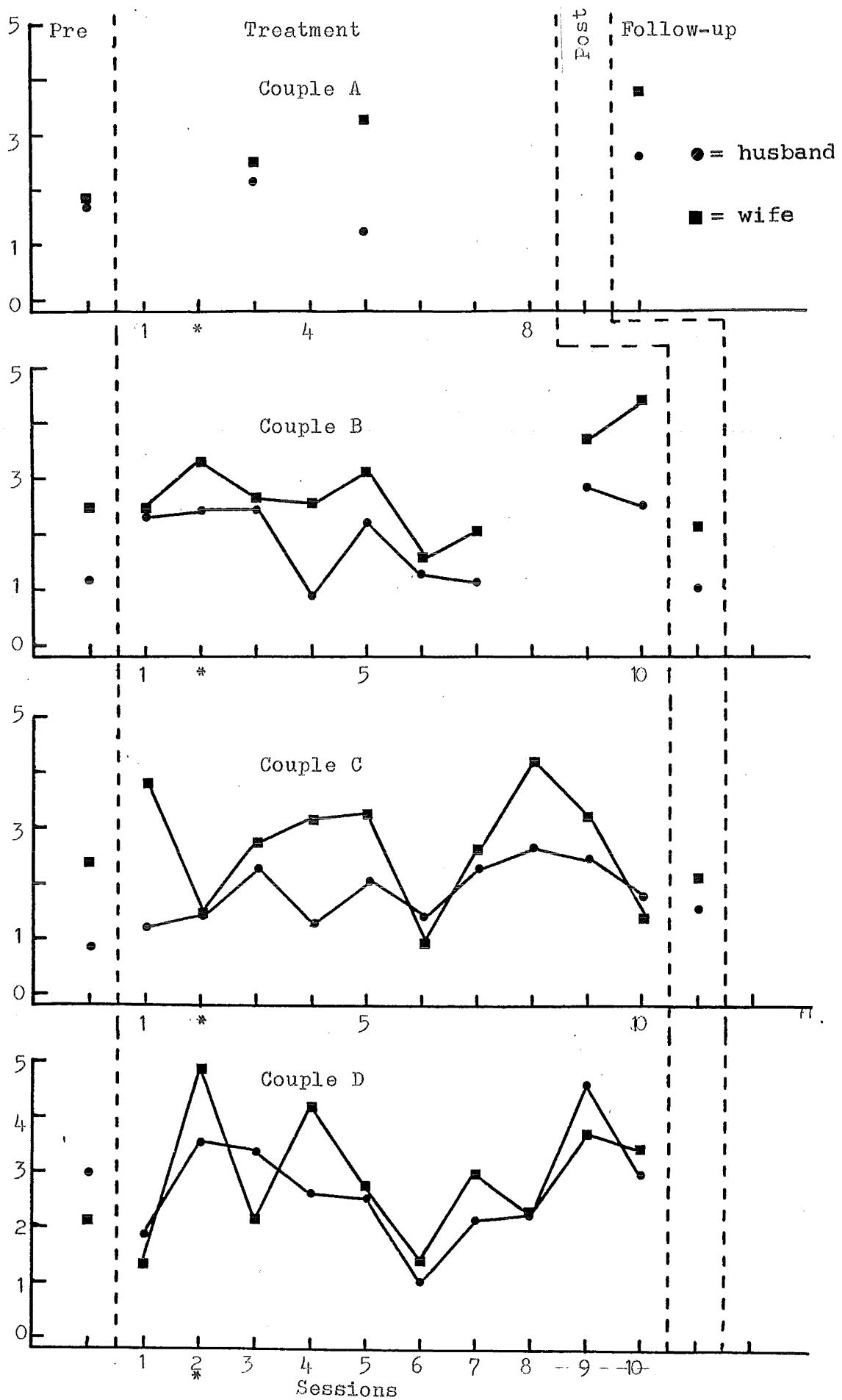


Fig 9 Rate of positive communication
* Communication training began.

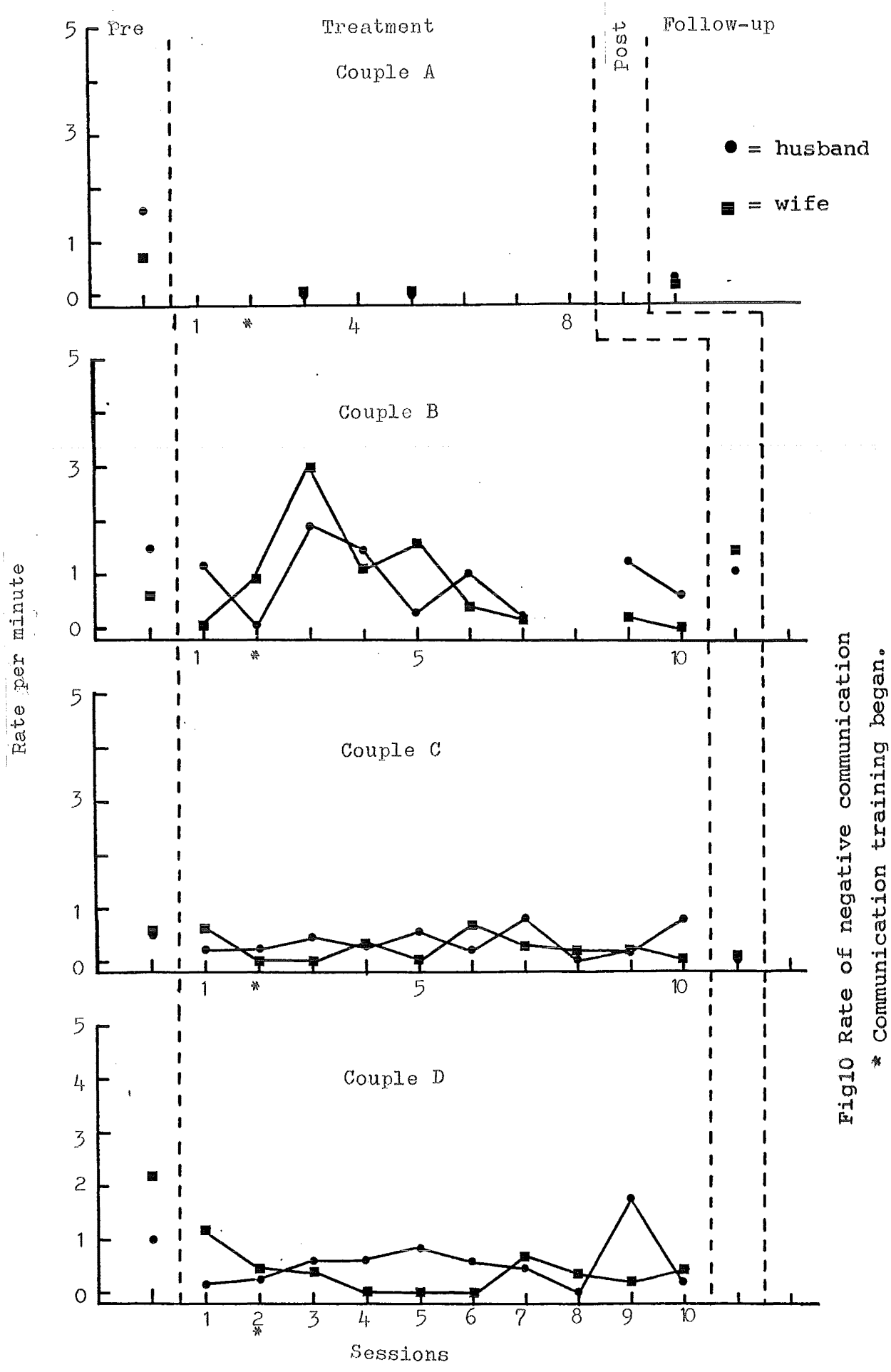


Fig10 Rate of negative communication
* Communication training began.

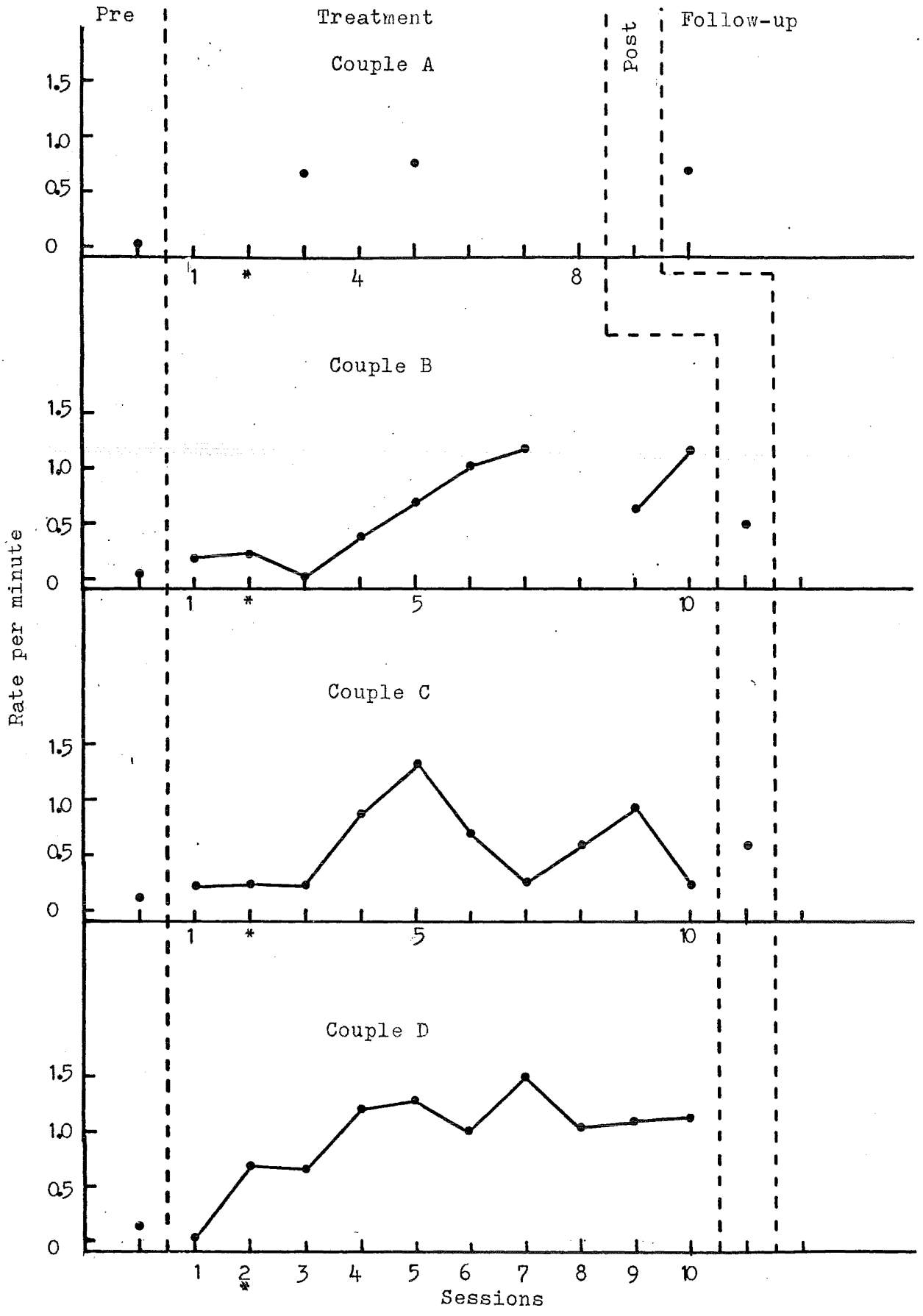


Fig11 Rate of Communication Talk

* Training in CT began.

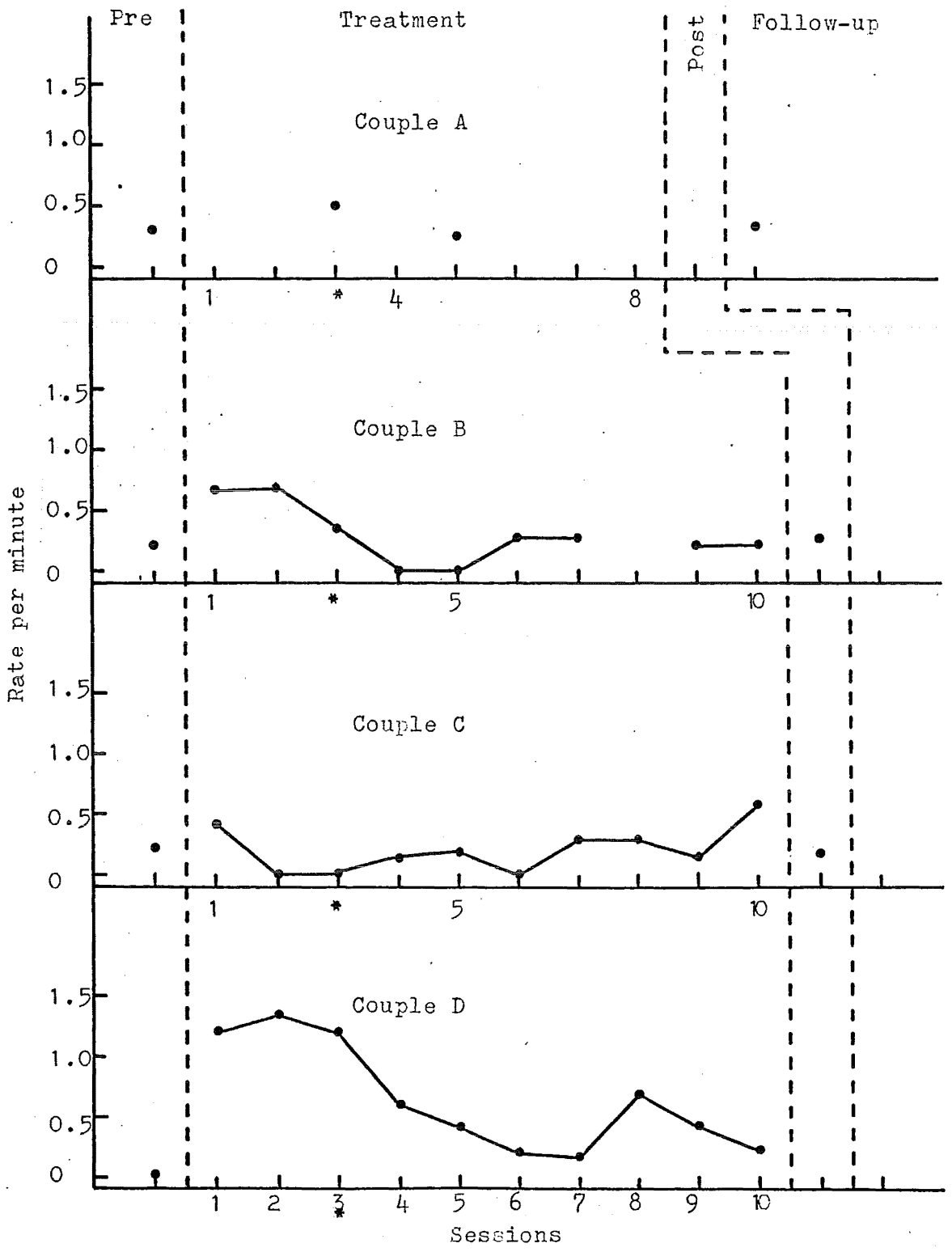


Fig12 Rate of Feeling Talk

* Training in FT began.

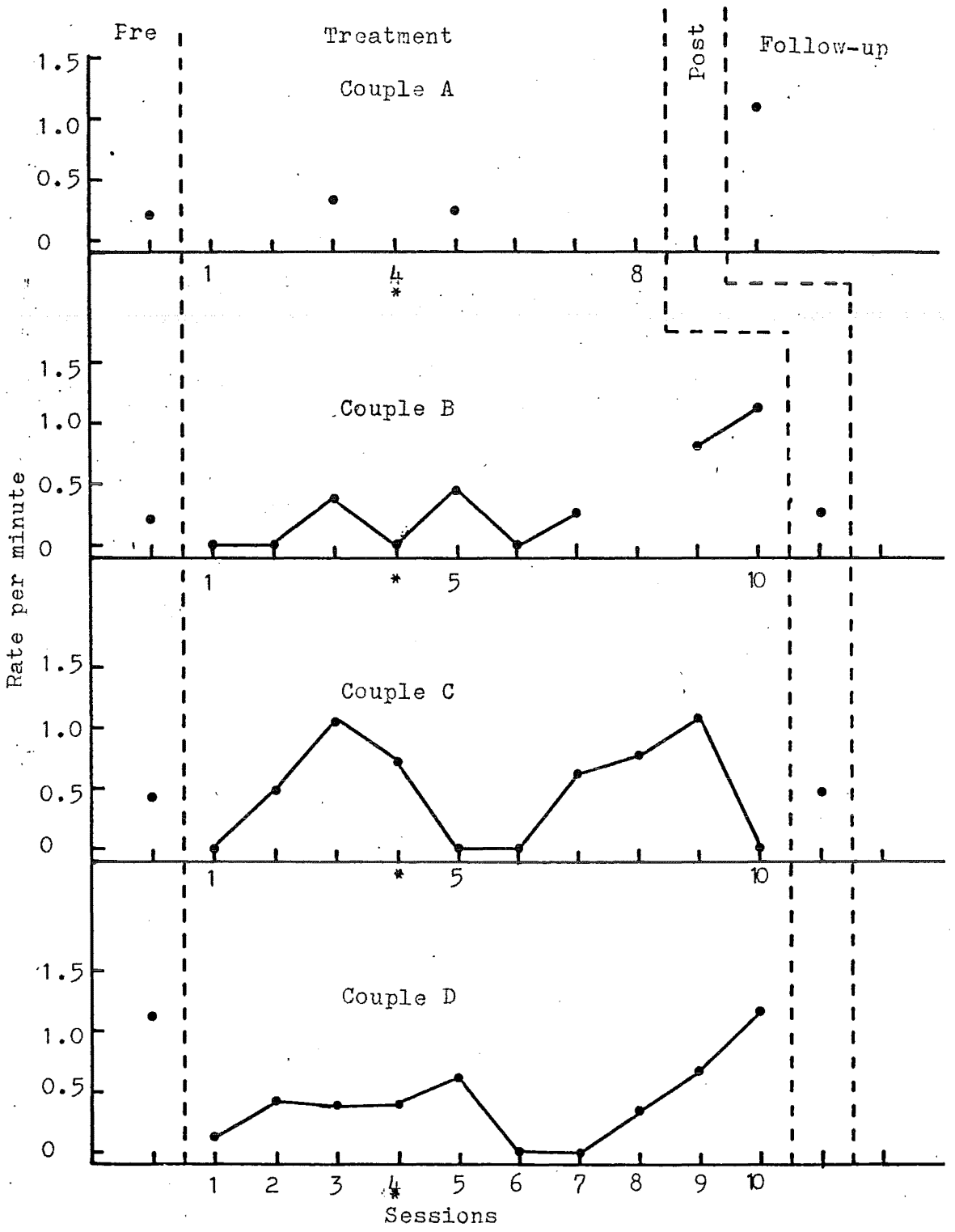


Fig 13 Rate of Solution Generation

*. Training in SG began.

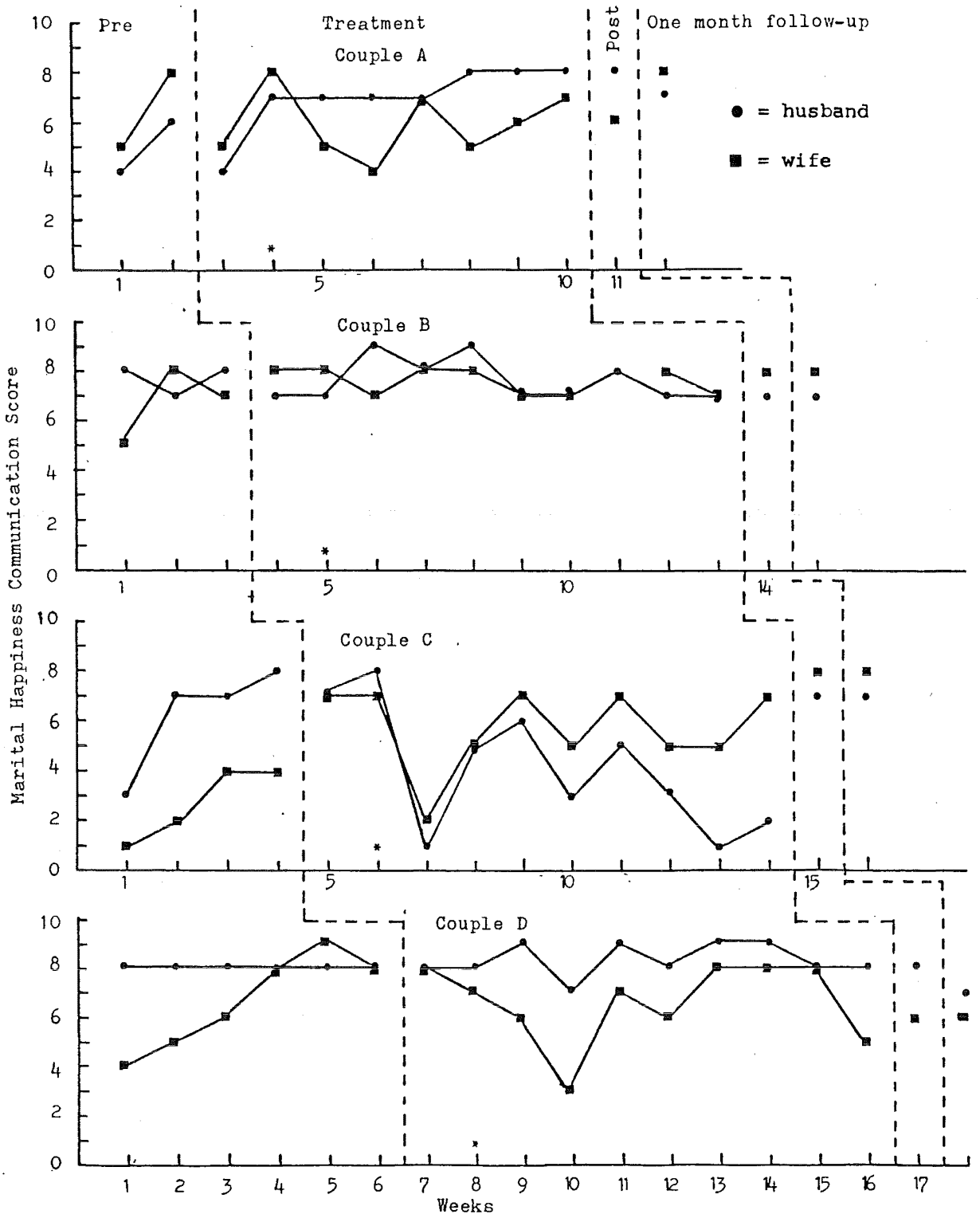


Fig14 Communication score of MHS data
*Communication training began

Table 11 Regression and correlation coefficients of the positive and negative communication scores between husband and wife, during treatment.

Couple	Communication	Regression Coefficient	Correlation Coefficient	df
A	Positive	0.490	0.363	2
	Negative	0.436	0.999 (0.001)	2
B	Positive	0.859	0.629 (0.05)	7
	Negative	0.777	0.534	7
C	Positive	0.850	0.420	8
	Negative	-0.343	-0.363 (0.05)	8
D	Positive	0.763	0.660	8
	Negative	-0.320	-0.439	8

(x) = level of significance

positive communication was higher than their respective pre-treatment rates.

Negative Communication

The negative communication rates of Couple A showed a significant drop from pre-treatment during treatment and follow-up. Couple B's rate was variable and showed no marked change. Similarly Couple C's rate was variable, however, at post-treatment their negative communication rate was near zero. In the last couple, both husband and wife showed a consistent decrease in their negative communication scores over treatment from pre-treatment.

Individual Communication Codes

Three communication code categories were plotted to see if they specifically improved. Communication Talk, Solution Generation and Feeling Talk, were chosen because each of these areas were focused on during training. Communication Talk training began in Session Two, while the discussion of feelings started in the following session. Solution Generation was gradually built up throughout the last stages of training, beginning in Session Four with the 'asking for a please' exercise. Of the three, Communication Talk showed the most consistent and biggest improvements. There was generally little variation between pre- and post-treatment rates of couple's feeling talk, although Couple B and D showed elevated levels during the first half of treatment. No consistent trend was observable from Solution Generation rates. While Couple B and D had slight increases at the end of treatment, their final rates were no different from pre-treatment. Couple A at follow-up did show a marked improvement. To make a comparison with the behavioural data

from the couples communication, the self-ratings of each spouse's 'happiness with communication' were taken from their MHS scores and plotted. Even though these were individual scores their graphs generally resembled their total MHS graphs. It was particularly noticeable in Couple C and Couple D, that strong fluctuation during treatment followed similar trends in both couples. While 'happiness with communication' ranged from 1 to 8 at the start of pre-treatment, at post-treatment all scores ranged between 6 and 8. However, in most cases, their post-treatment scores differed by only 1 or 2 points from their scores at the end of the pre-treatment phase. Except for Couple A all correlations between negative or positive communication rates and MHS communication scores were small and non-significant. Couple A's positive communication/MHS-communication correlation was 0.833, however, because of the small number of data points it was not statistically significant.

DRINKING BEHAVIOUR

The MAST scores, as expected, correctly indicated all the problem drinkers. However, it also gave two out of the three spouses who had no alcohol problems false positive results (see Couples A & B). This may suggest that the MAST gives a high rate of 'false positive' results to spouses of problem drinkers. All abstinent subjects remained abstinent during the research. The husband of Couple C, whose drinking was identified by his wife as one of the problem areas of the marriage, was asked to record his drinking over different phases: before, during and after marital therapy. His daily consumption was calculated in terms of absolute alcohol drunk. He reported drinking on average 3.0 ounce (87.5 mls) of

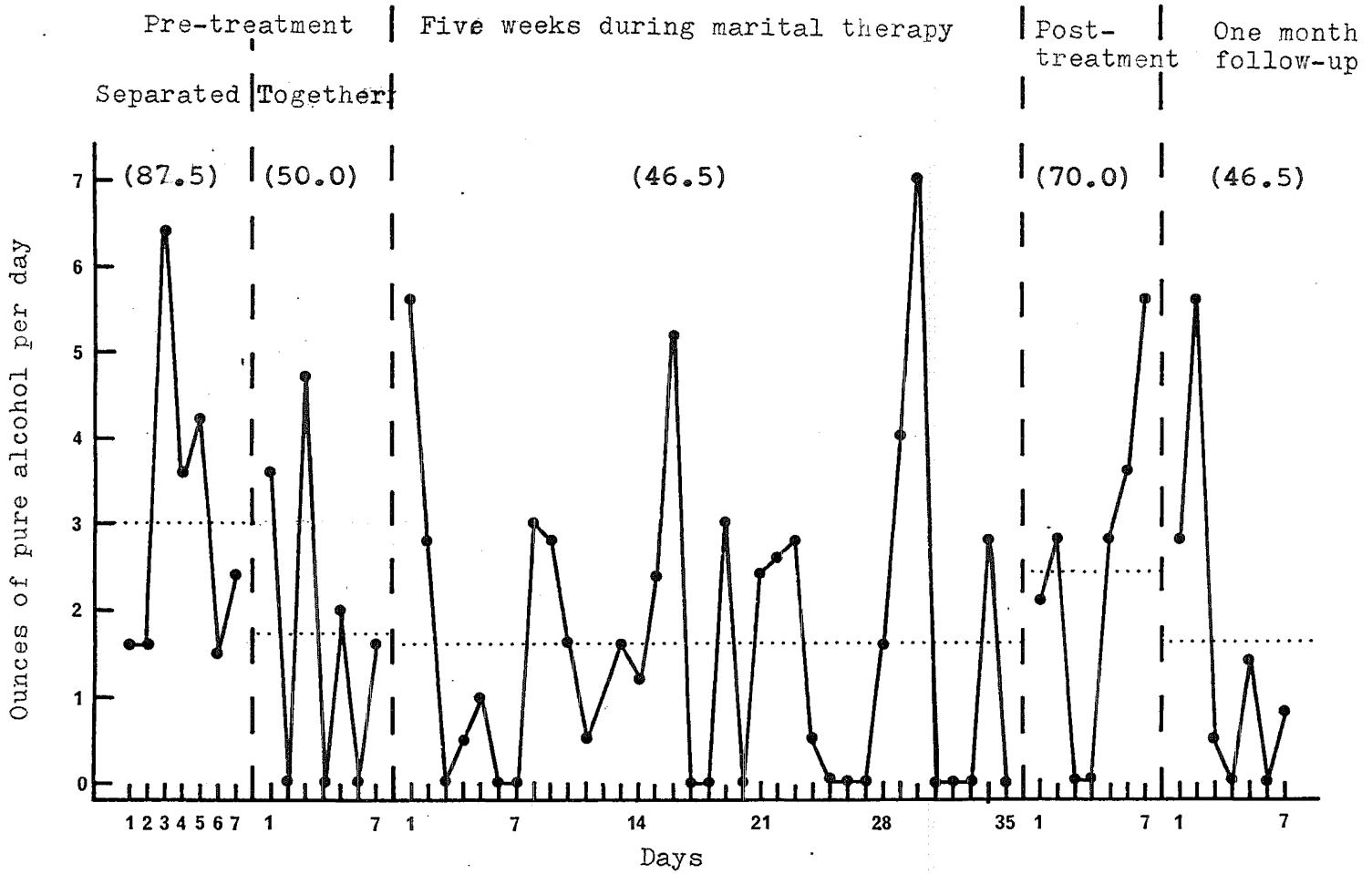


Fig15 Daily consumption of alcohol, of husband (Couple C) before, during and following marital therapy. (x) = mean volume drunk in millilitres.

absolute alcohol per day while he and his wife were separated, before treatment. When they moved back together his drinking decreased to a mean of 1.7 ounces (50 mls) of absolute alcohol per day, and this drop was maintained throughout the five weeks he recorded during marital therapy. At post-treatment there was a reported rise to an average of 2.4 ounces (70 mls) per day. However, it fell again to 1.6 ounces (46.6 mls) per day at follow-up.

In a national survey of New Zealand drinking habits (Caswell, 1980), Caswell used a criterion for "heavy drinking" in men of a mean of 60 mls or more of absolute alcohol per day. Although previous research had linked the self-reported use of 80 mls or more of absolute alcohol per day with an increased risk to health, a lower criterion was used because Caswell found evidence that self-reported drinking underestimated the amounts consumed.

Using the survey as a comparison, the husband's drinking (Couple C) would place him within the top 14-18% of New Zealand men with respect to their intensity of drinking. At the initial part of pre-treatment and at post-treatment he was drinking "heavily". The drop in his drinking intensity during the other phases was attributed to an increase in the days he was abstinent, rather than a decrease in the amount consumed in any drinking episode.

Near the end of marital therapy an opportunity was given to the wife to put forward her dissatisfaction with her husband's drinking and to negotiate a mutually acceptable level of drinking if wanted. At that stage she was quite satisfied with her husband's present level. This acceptable level of drinking was further defined in terms of the days the husband was permitted to visit the hotel and for how long.

MARITAL GRIDS

Repertory Grids

To aid comprehension, because of the large amount of information in each repertory grid, the repertory grids have been systematically analysed with respect to:

(a) the respondents' satisfaction with their performance in the marriage.

(b) the perception of the spouses' satisfaction with their own performance in the marriage

and (c) how the respondents compared themselves to the average New Zealand husband or wife of their sex.

These have been listed so that the perceptions of each partner can be compared for each couple. Only those areas in the marriage which accounted for at least 10 per cent of the total construct variance were listed. (The percentage variance of each construct ranged, on average, from 0 to about 50%. Constructs of 10 or more per cent variance were assumed to be the most salient areas of the marriage at each stage).

Figures 16 are an example set of repertory grids.

Key to Grid Elements

○ = Own satisfaction with one's performance in....

● = Perceived-spouse' satisfaction with own performance in....

▲ = Own satisfaction with spouse's performance in....

△ = Perceived-spouse' satisfaction with his/her performance in....

■ = Average N.Z. husband's satisfaction with his performance in....

□ = Average N.Z. wife's satisfaction with her performance in....

COUPLE A	HUSBAND	WIFE
	Husband was more satisfied with his:	Wife believed her husband was more satisfied with his:
Pre-treatment	Employment and education	Employment and education Child care and parenting Financial management
Post-treatment	Child care and parenting Involvement in household management	She believed her husband was generally less satisfied
Follow-up	Employment and education	Being considerate
	Husband believed his wife was more satisfied with her:	Wife was more satisfied with her:
Pre-treatment	Child care and parenting Involvement in household management Giving of affection	Use of leisure time
Post-treatment	Being considerate Giving affection	Use of leisure time Employment and education Independence
Follow-up	Personal habits and appearance	Use of leisure time Providing companionship
Pre-treatment	He believed the average N.Z. husband was more satisfied with his: Providing of companionship	She believed the average N.Z. wife was more satisfied with her: Giving affection
Post-treatment	Independence	She believed the average N.Z. wife was generally less satisfied
Follow-up	Ability to communicate and sexuality	" " " " " " " " " "

COUPLE B	HUSBAND	WIFE
	Husband was more satisfied with his:	Wife believed her husband was more satisfied with his:
Pre-treatment	Financial management Sexuality Independence	Financial management Sexuality
Post-treatment	Financial management Use of leisure time	Financial management Sexuality
Follow-up	Financial management Independence	Financial management Sexuality
	Husband believed his wife was more satisfied with her:	Wife was more satisfied with her:
Pre-treatment	Employment and education Child care and parenting	Involvement in household management Being considerate
Post-treatment	Employment and education Child care and parenting	Employment and education Independence
Follow-up	Child care and parenting Involvement with household management Ability to communicate	Child care and parenting Involvement with household management
Pre-treatment	Husband believed to be as satisfied as the average N.Z. husband	Wife believed to be as satisfied as the average N.Z. wife
Post-treatment	" " " " " " " " "	Wife believed the average N.Z. wife was generally less satisfied
Follow-up	Husband believed the average N.Z. husband to be generally less satisfied	" " " " " " " " " "

COUPLE C	HUSBAND	WIFE
	Husband was more satisfied with his:	Wife believed her husband was more satisfied with his:
Pre-treatment	Independence Use of leisure time	Employment and education
Post-treatment	Providing companionship Use of leisure time Financial management	Employment and education Independence
Follow-up	Employment and education Being considerate	Employment and education Giving affection Sexuality
	He believed his wife was more satisfied with her:	She was more satisfied with her:
Pre-treatment	Sexuality Ability to communicate	Child care and parenting Ability to communicate
Post-treatment	(He believed his wife was generally less satisfied than him)	Financial Management Child care and parenting
Follow-up	Involvement in household management	(She was generally less satisfied than her husband)
Pre-treatment	He believed the average N.Z. husband was more satisfied with his: Ability to communicate	She believed the average N.Z. wife was generally less satisfied
Post-treatment	Giving affection, personal habits and appearance	" " " " " " " " " "
Follow-up	Giving affection	" " " " " " " " " "

COUPLE D	HUSBAND	WIFE
	Husband was more satisfied with his:	Wife believed her husband was more satisfied with his:
Pre-treatment	Involvement with household management	Use of leisure time Personal habits and appearance
Post-treatment	Being considerate Financial management	Use of leisure time Independence Employment and education
Follow-up	Being considerate Ability to communicate Employment and education	Use of leisure time Independence
	He believed his wife was more satisfied with her:	She was as satisfied as her husband with:
Pre-treatment	Use of leisure time Sexuality	Child care and parenting
Post-treatment	Independence	She was generally less satisfied than her husband
Follow-up	He believed his wife was generally less satisfied	She was more satisfied with her sexuality
Pre-treatment	He believed the average N.Z. husband was more satisfied in his: Sexuality Use of leisure time	She believed the average N.Z. wife was as satisfied as her
Post-treatment	Independence	" " " " " " " " " " "
Follow-up	Sexuality	" " " " " " " " " " "

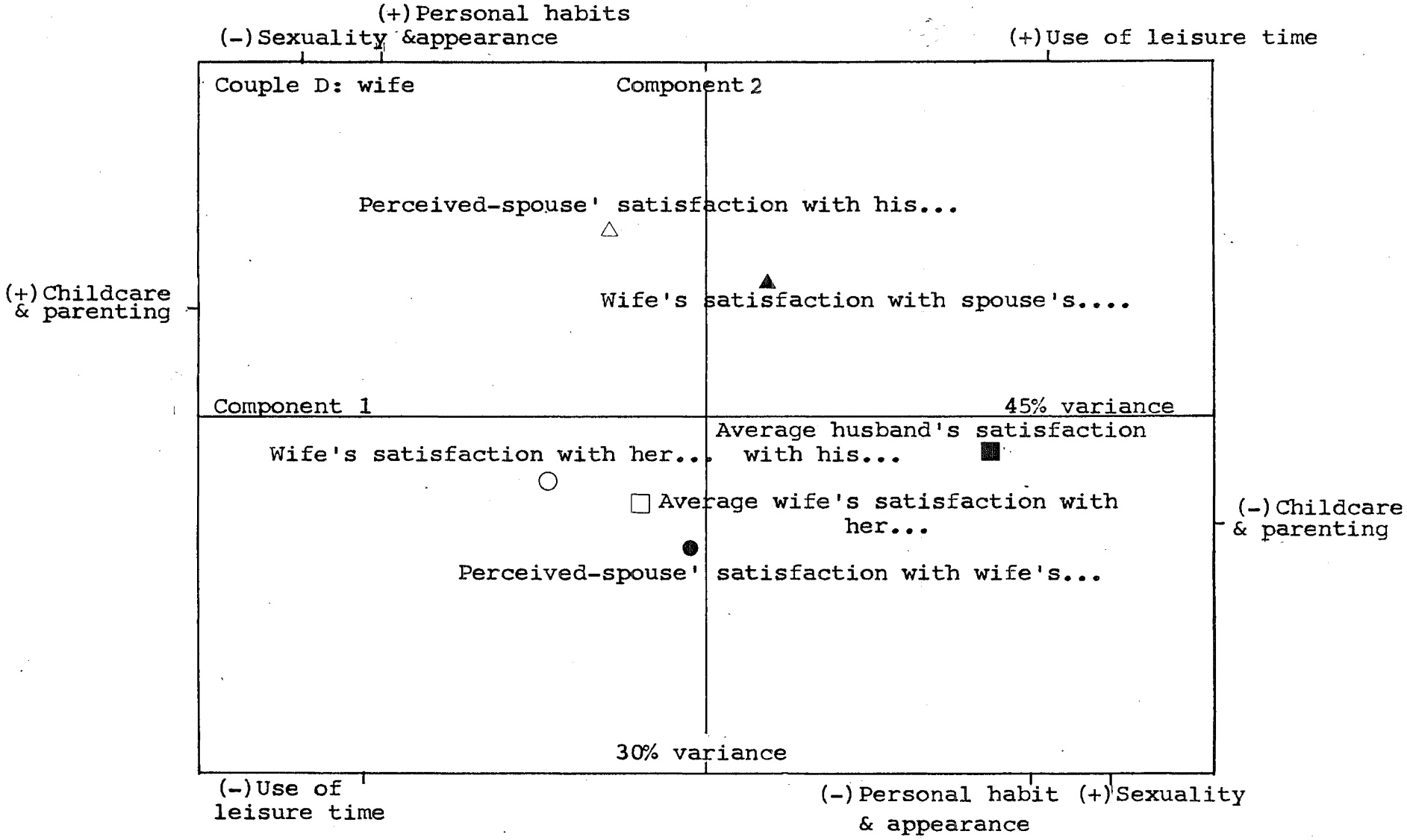


Fig 16(a) An example of one set of repertory grids. The wife's repertory grid at pre-treatment.
(+) = high level of satisfaction (-) = low level of satisfaction

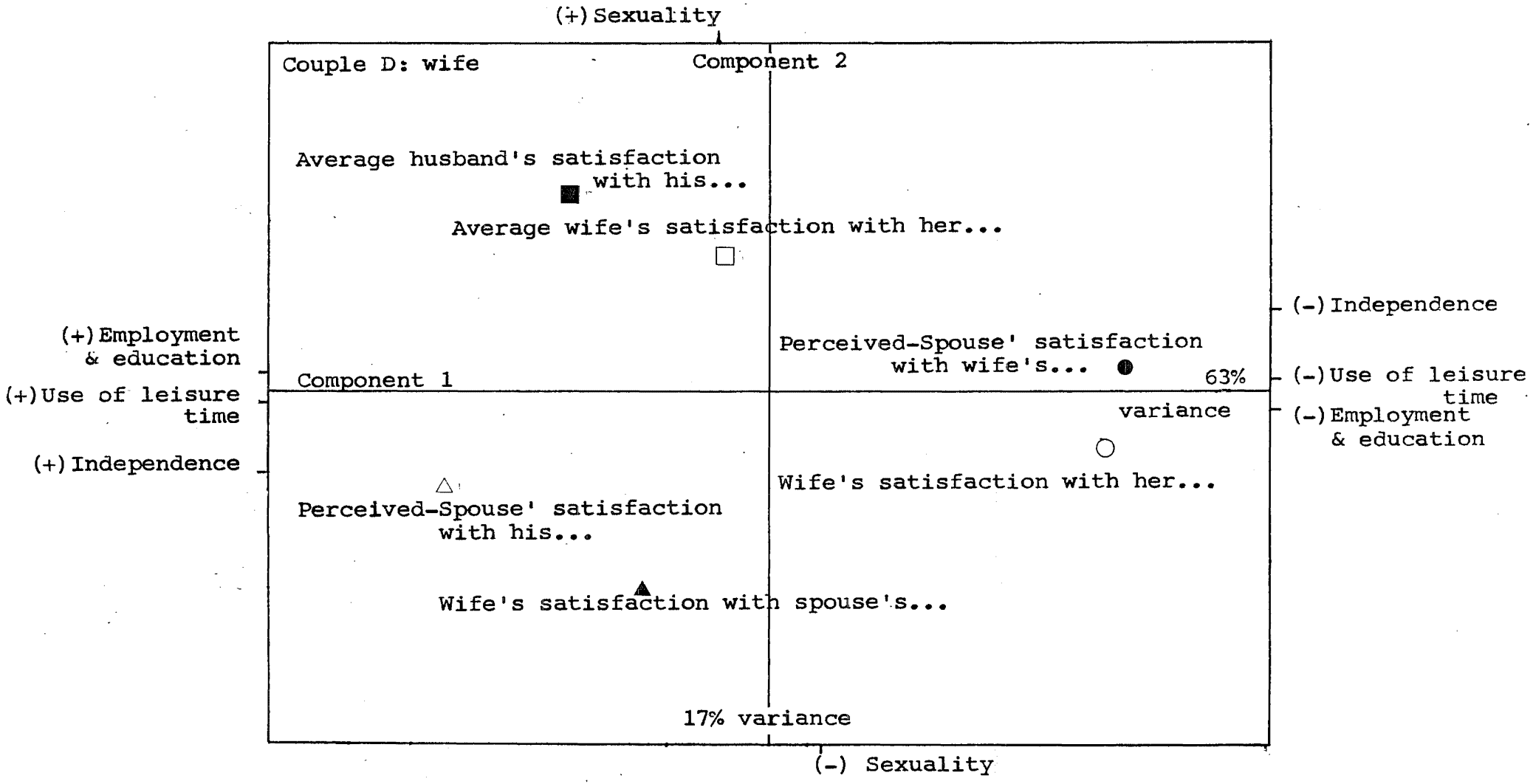


Fig 16(b) The wife's repertory grid at post-treatment
(+) = high level of satisfaction (-) = low level of satisfaction

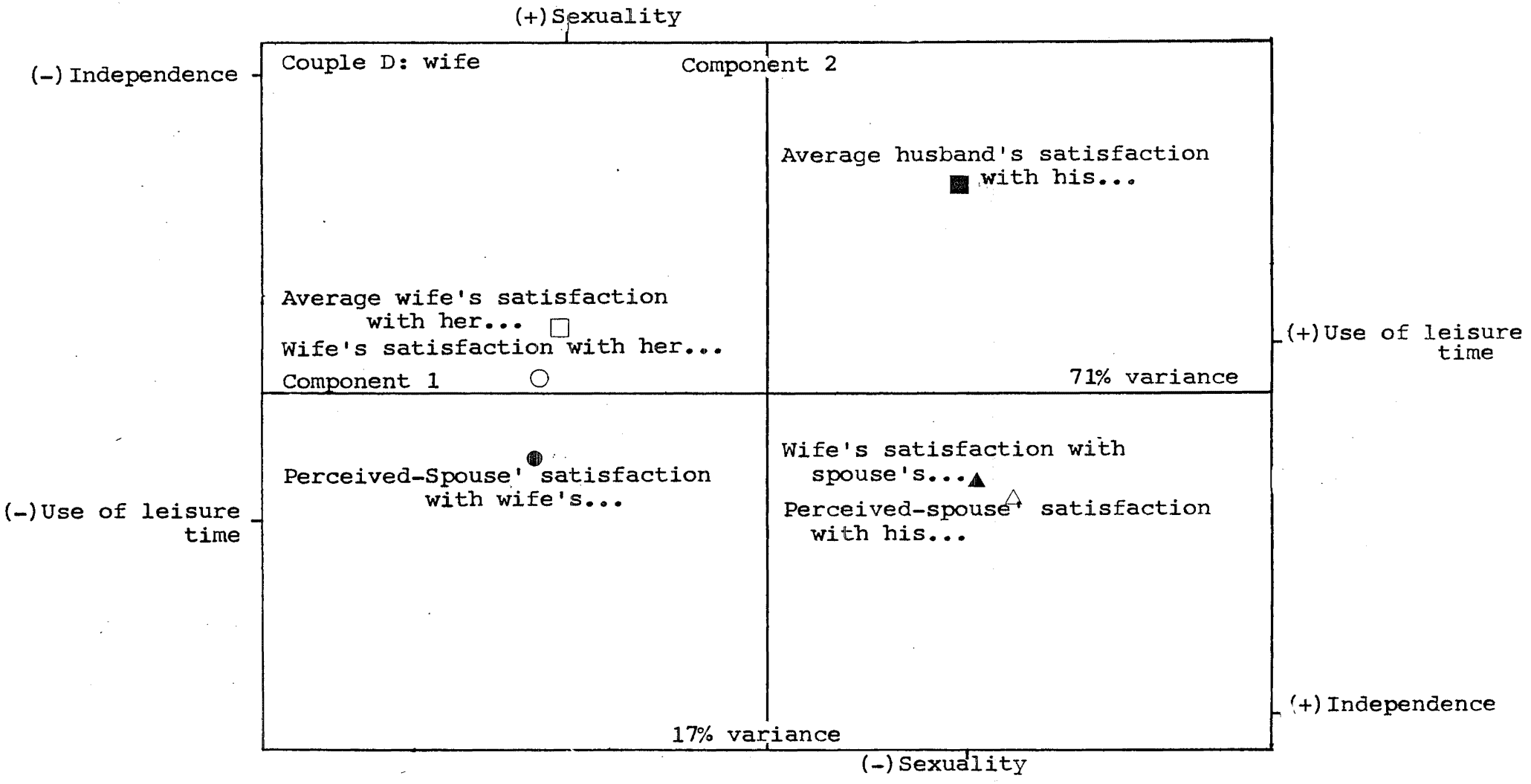


Fig 16(c) The wife's repertory grid at follow-up
(+) = high level of satisfaction (-) = low level of satisfaction

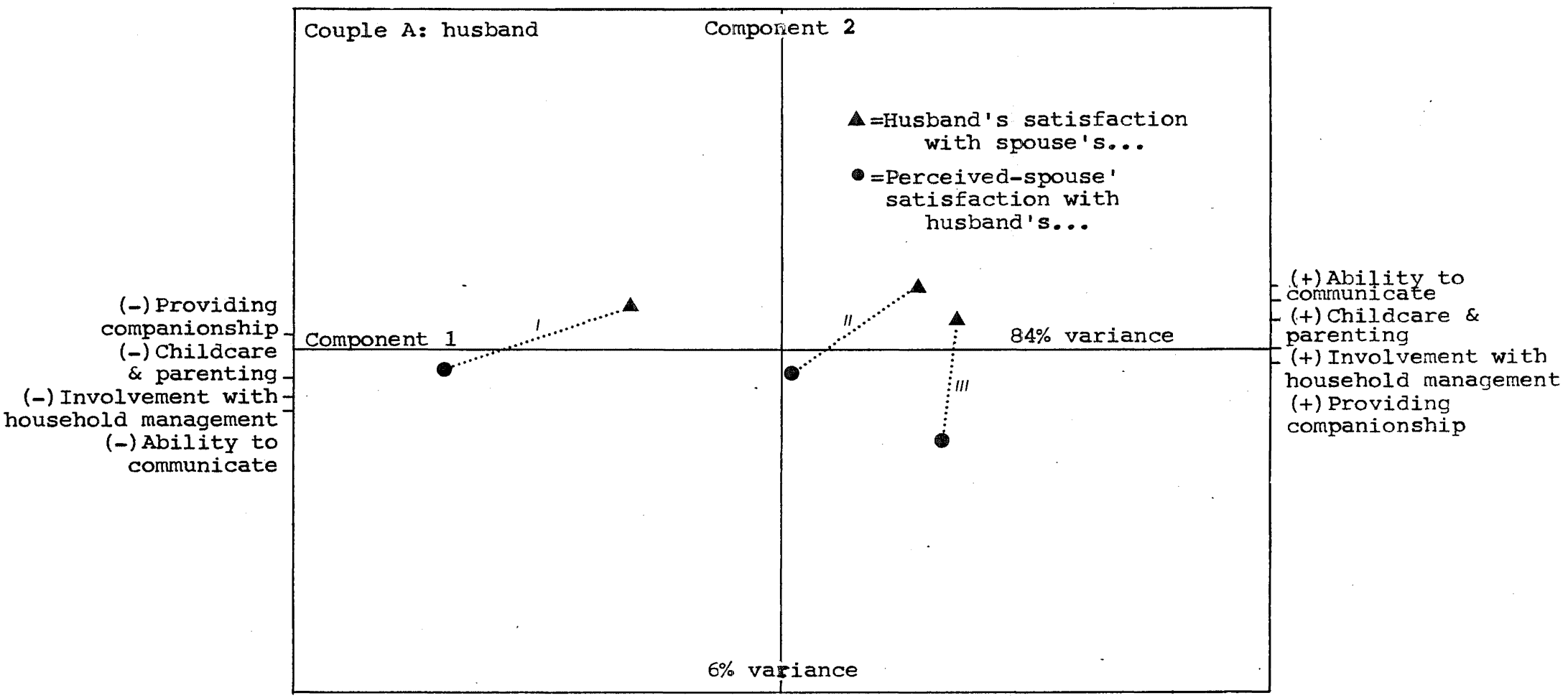


Fig 17 The husband's reconstruction grid (Couple A). 1=Pre-treatment; 11=Post-treatment
(+) = high level of satisfaction 111=Follow-up.
(-) = low level of satisfaction

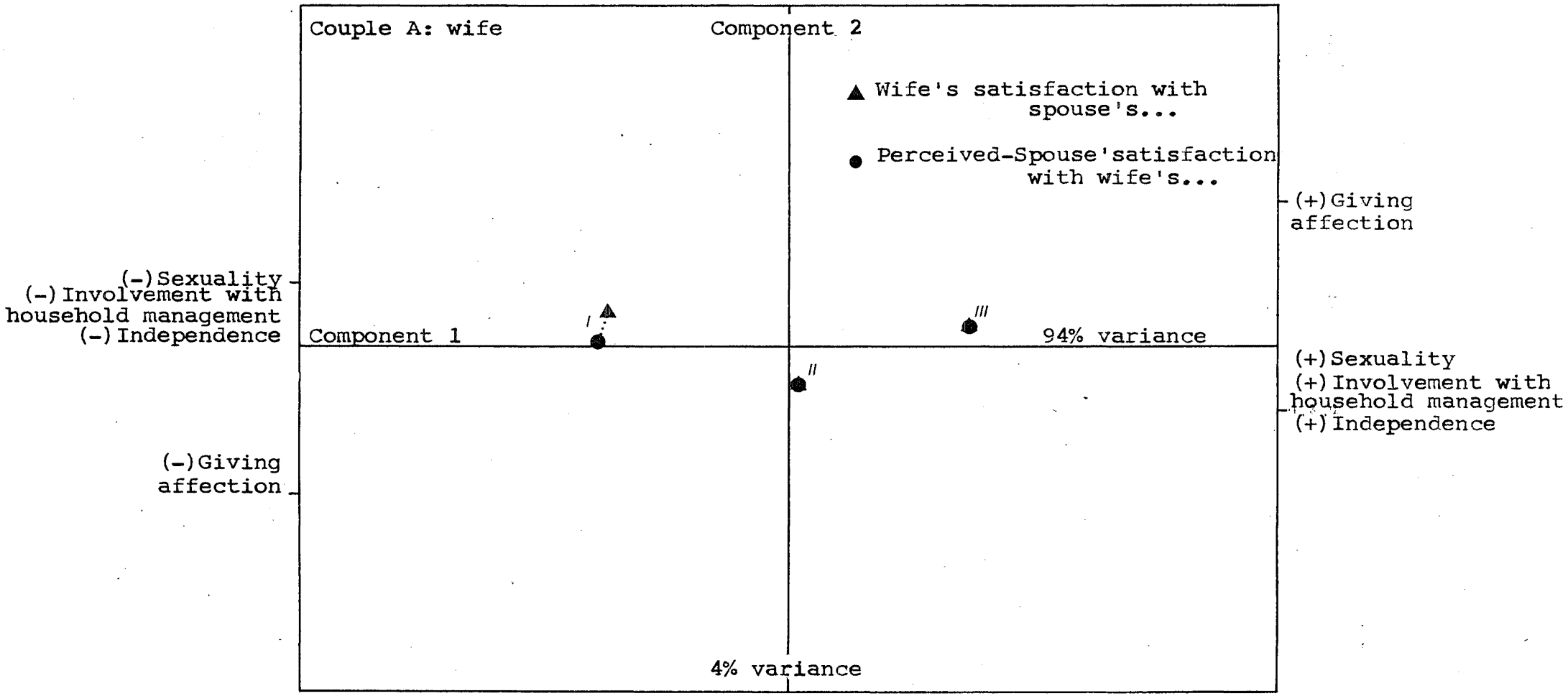


Fig 18 The wife's reconstruction grid (Couple A). 1=Pre-treatment; 11=Post-treatment; 111=Follow-up
(+) = high level of satisfaction (-) = low level of satisfaction

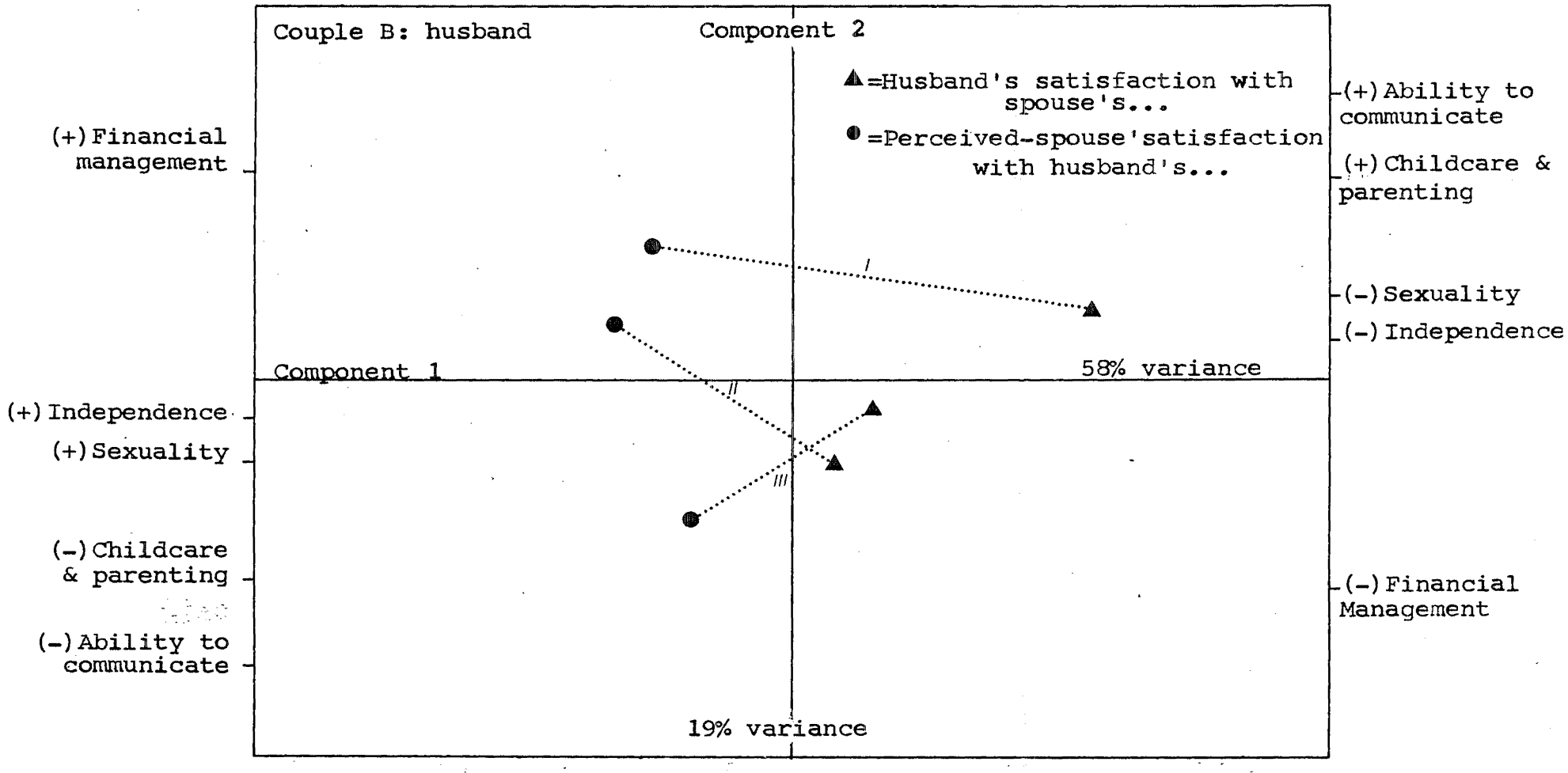


Fig 19 Husbands reconstruction grid (Couple B) 1=Pre-treatment; 11=Post-treatment; 111=Follow-up
(+) = high level of satisfaction (-) = low level of satisfaction

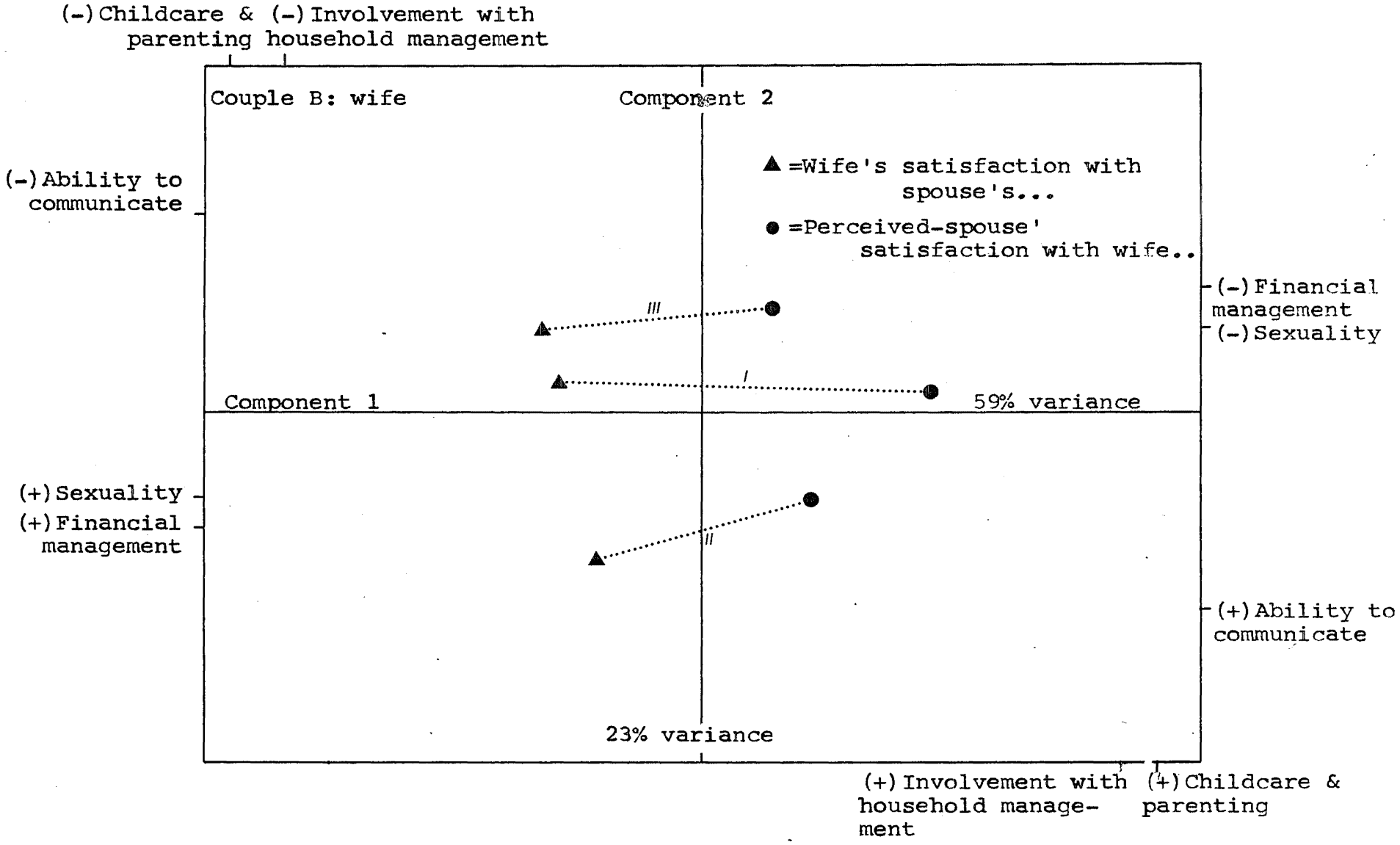


Fig 20 Wife's reconstruction grid (Couple B) 1=Pre-treatment; 11=Post-treatment; 111=Follow-up
(+) = high level of satisfaction (-) = low level of satisfaction

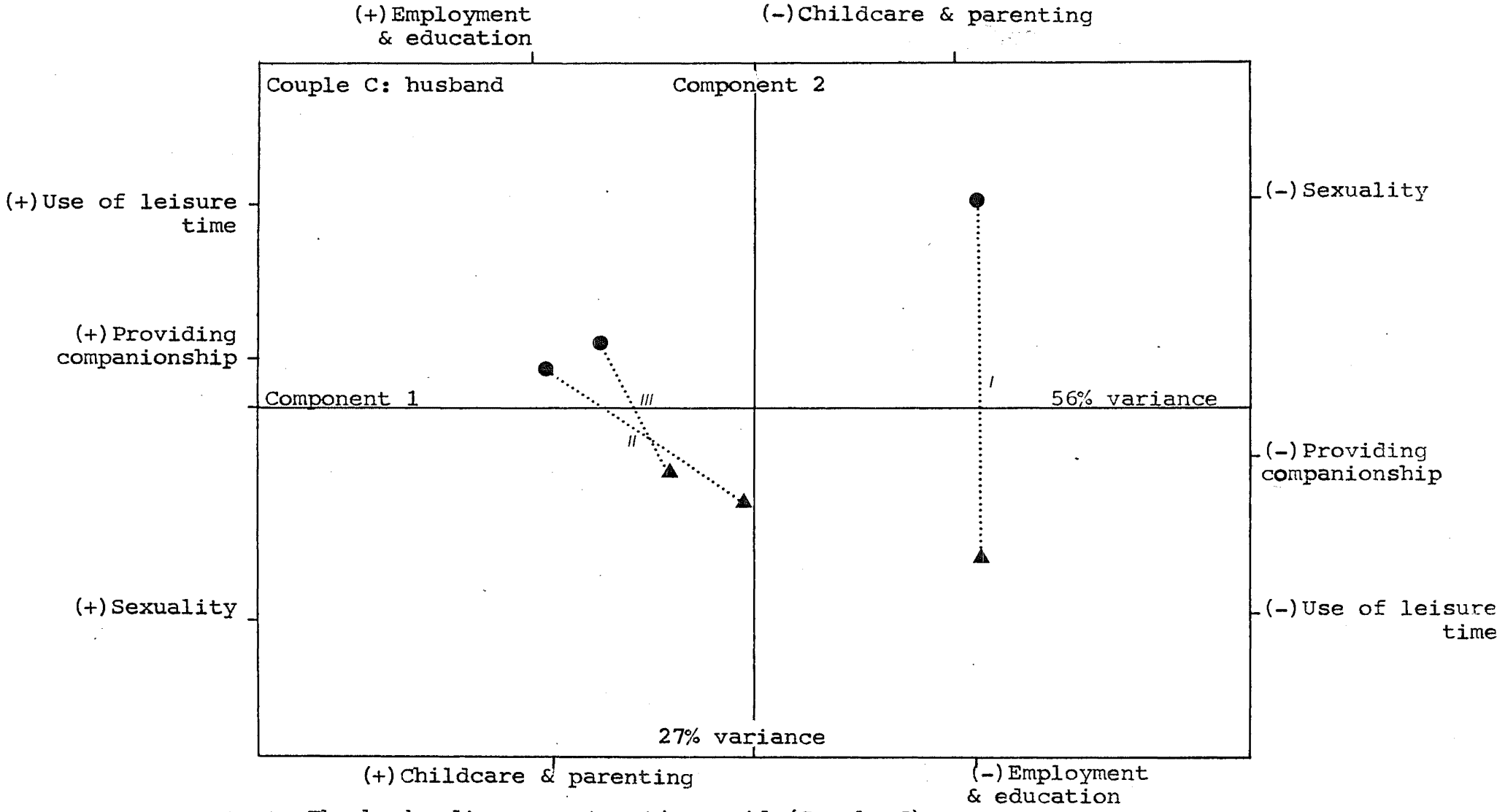


Fig 21 The husband's reconstruction grid (Couple C)
Key same as before.

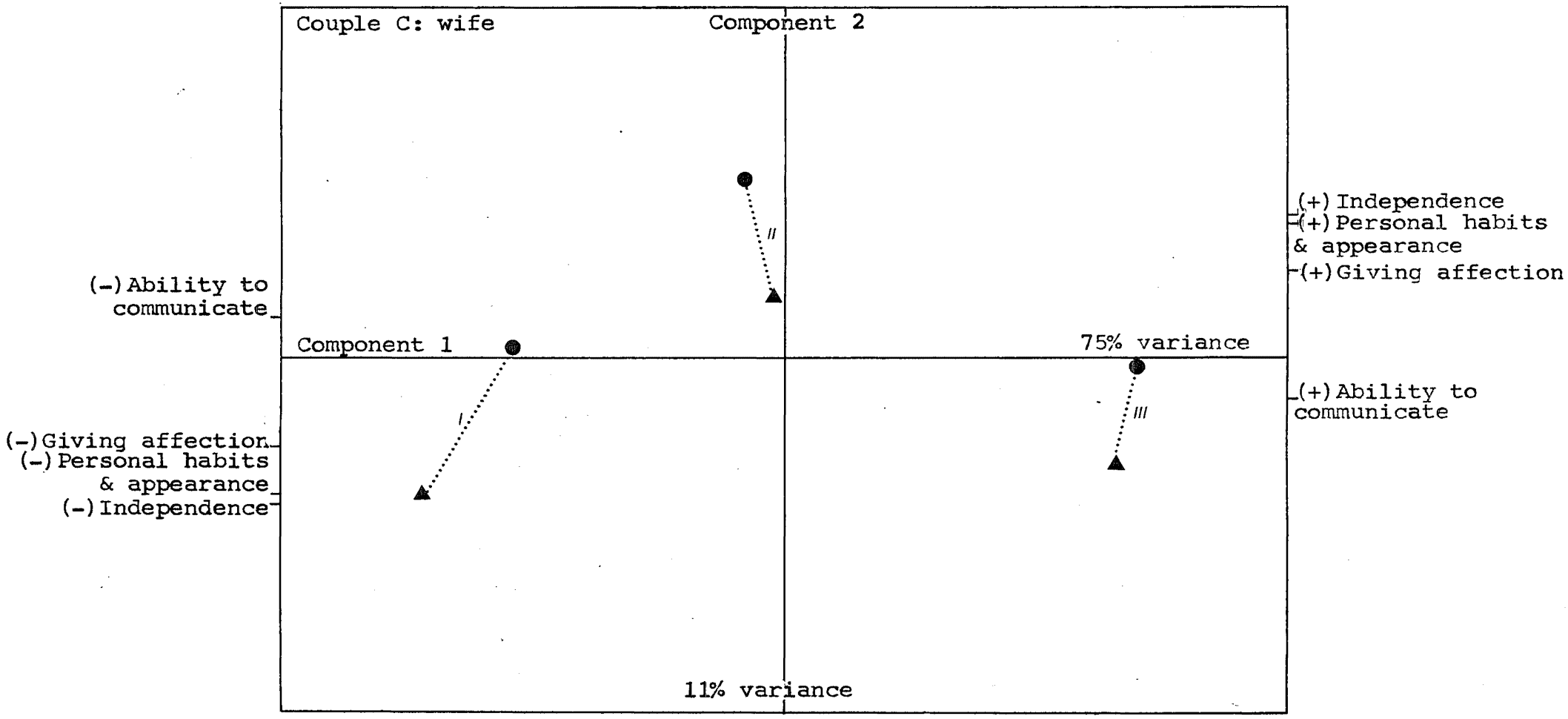


Fig 22 Wife's reconstruction grid (Couple C)
Key same as before.

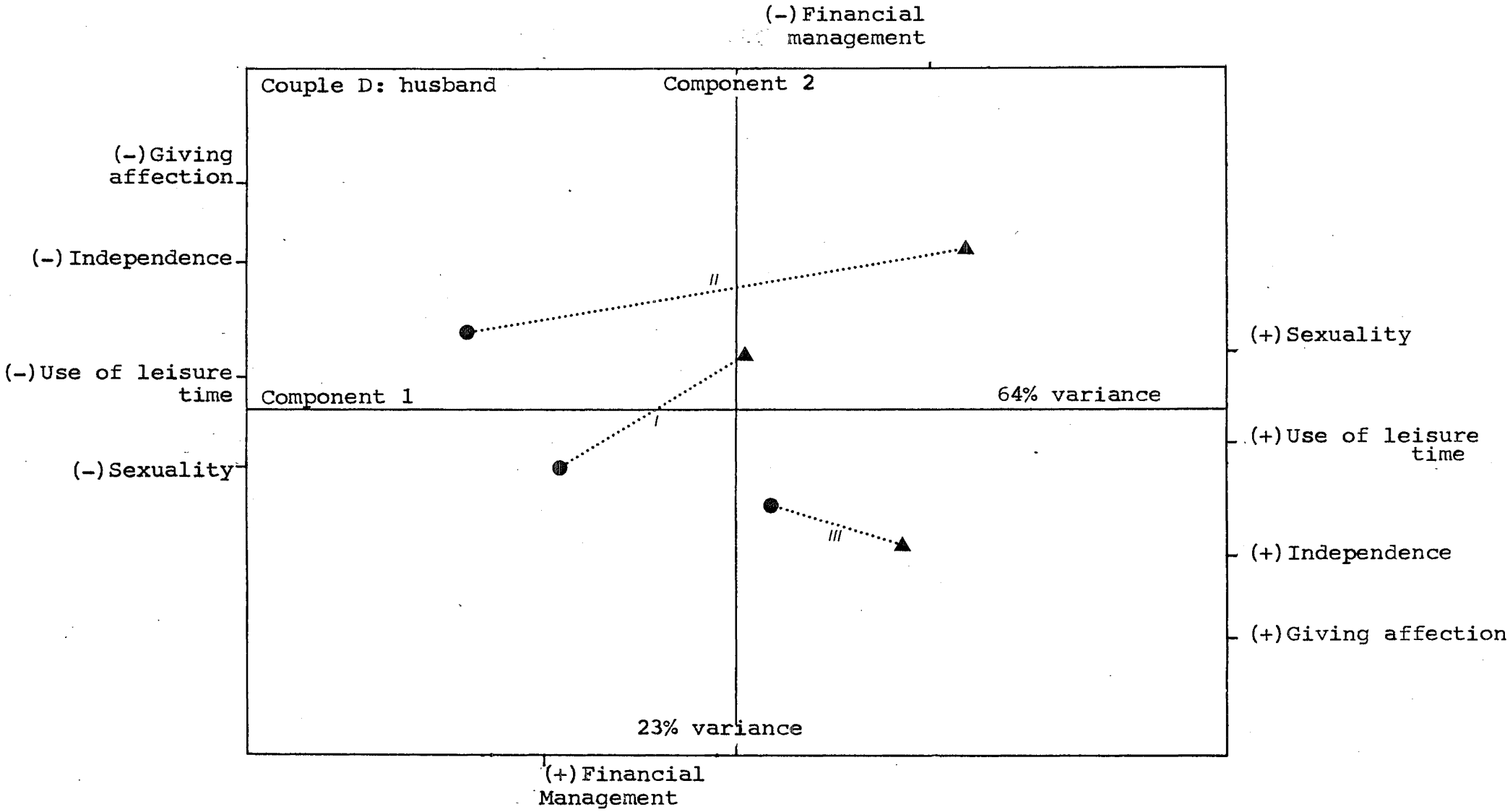


Fig 23 The husband's reconstruction grid (Couple D) Key same as before.

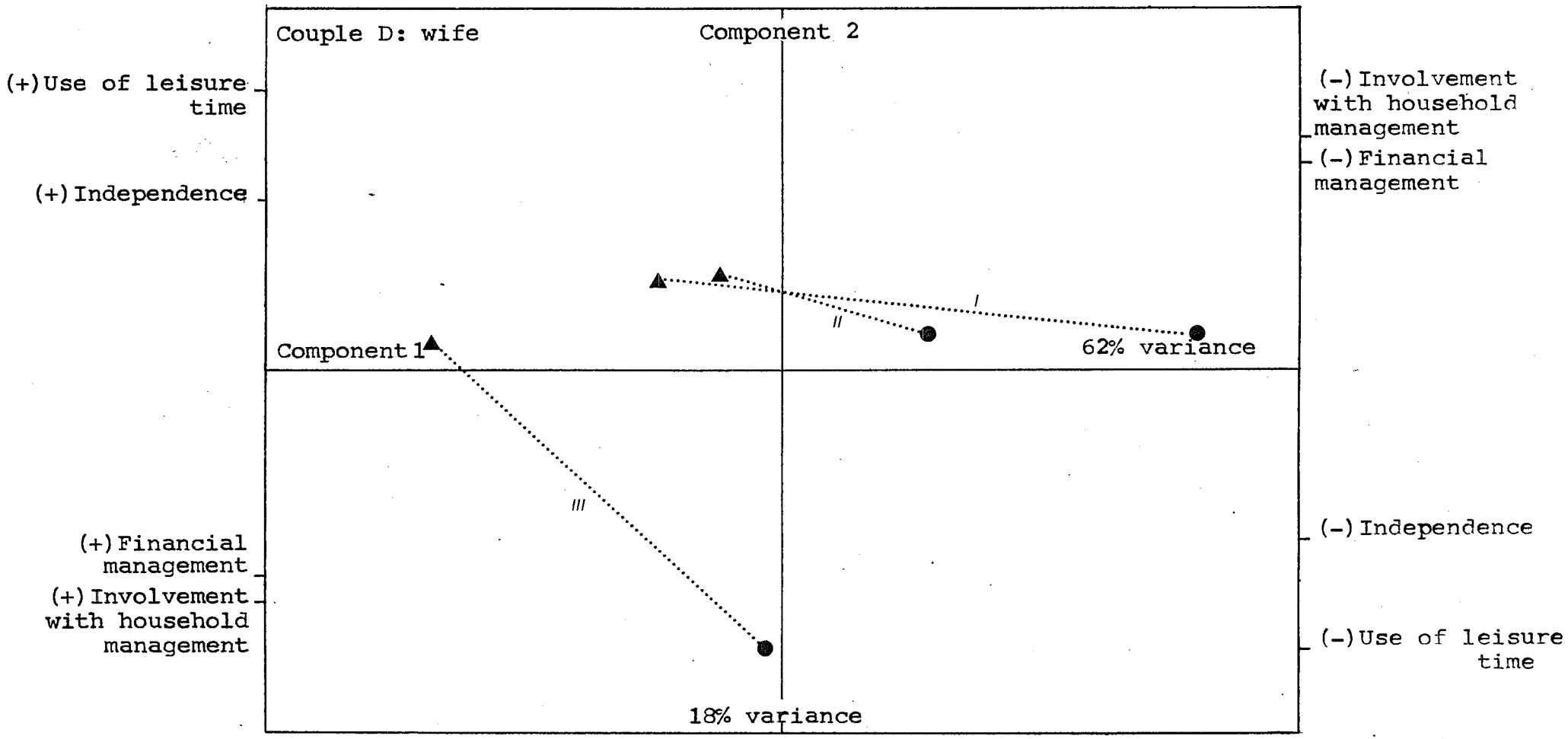


Fig 24 The wife's reconstruction grid (Couple D)
Key same as before.

Reconstruction Grids

Couple A. The husband's reconstruction grid showed that he believed that both his and his partner's satisfaction of each other increased across most areas of their marriage over time, (particularly in their communication, childcare, companionship and household management).

The wife's grid displayed a similar increase in satisfaction over time. By post-treatment she felt their satisfaction of each other coincided.

Couple B. The husband's reconstruction grid revealed no major change over time, in terms of his view of each partner's relative satisfaction. He was more satisfied with his wife's ability to communicate and her childcare than with her sexuality, independence and financial management. His wife, he believed, had an opposite perception of him, being more satisfied with his financial management, sexuality and independance than his childcare and ability to communicate.

Indeed, the wife was generally more satisfied with her partners financial management and sexuality, than she believed he was with hers. At post-treatment she felt there was an improvement in their satisfaction of each other's communication, childcare, and involvement in household management. By follow-up, however, their satisfaction had decreased to below pre-treatment levels.

Couple C. The husband's grid showed that he believed that his wife was more satisfied with his employment and education than he was with her's. Over the course of therapy he perceived an increase in their satisfaction of each other's use of leisure time, companionship, sexuality and childcare. At post-treatment, there was less discrepancy between them.

The wife also perceived an increase in their satisfac-

tion of each other. She, however, saw the greatest changes occurring with respect to their personal habits and appearance, giving affection, communication and independence.

Couple D. The husband's reconstruction grid revealed that he felt his partner was dissatisfied with his sexuality, use of leisure time, independence and affection, but satisfied with his financial management. He was satisfied with his wife in most of these areas. This difference was greatest at post-treatment. He felt a large overall improvement in his wife's satisfaction with him at follow-up. At which stage, he was more satisfied with his wife's financial management.

The wife tended to be more satisfied with her partner's use of leisure time and independence, than she believed he was with her in these areas. Her reconstruction grid, nevertheless, showed that she believed her husband became more satisfied with her financial management, and involvement with household management.

Correlations

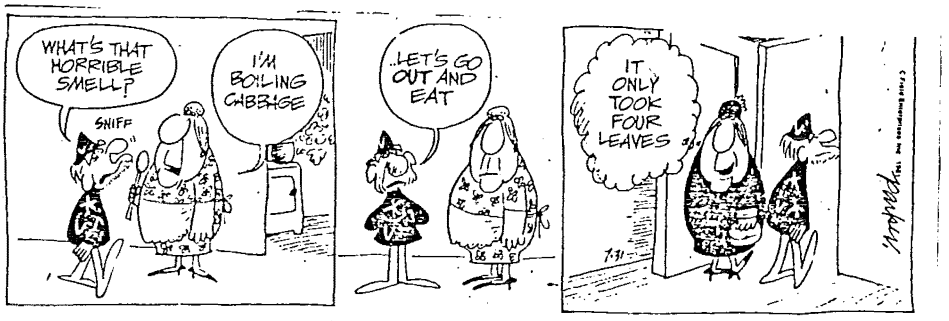
The correlations between couple's reconstruction grids reveal that Couple A were most similar in their perceptions. Couple D were the next most similar followed then by Couple C. The least similar were Couple B. Their correlation co-efficient was, nevertheless, statistically significant. The individual repertory grid correlations would suggest that the greatest changes in satisfaction occurred within Couples A and Couple C respectively, particularly from the wife in the first couple and the husband in the next. Couple D recorded the least change over time.

Table 16 Marital Grid Correlation Coefficients

Couple	Grids compared	Repertory grids husband	Repertory grids wife	Reconstruction grids husband - wife
A	Pre-Post	0.381	0.485	0.734
	Post-FU	0.592	0.636	
	Pre-FU	0.288 (0.02)	0.516	
B	Pre-Post	0.585	0.468	0.383
	Post-FU	0.526	0.556	
	Pre-FU	0.547	0.701	
C	Pre-Post	0.416	0.585	0.474
	Post-FU	0.344 (0.01)	0.628	
	Pre-FU	0.349 (0.01)	0.521	
D	Pre-Post	0.725	0.668	0.575
	Post-FU	0.746	0.676	
	Pre-FU	0.595	0.636	

All correlation were analysed at d.f. = 70 and all were statistically significant at 0.001 probability, except otherwise noted in brackets.

DISCUSSION



"...it (BMT) helps couples to use positive control tactics as a means of altering one another's behaviours..." (p.10).

There were improvements in MAT and ACQ scores at post-treatment and follow-up. Both measures have been shown to be powerful discriminators of distressed and non-distressed couples. ACQ scores generally dropped to non-distressed ranges. MAT scores however, even when they reached the 200 point cut-off were still on the borderline of distress, especially when compared to the mean MAT scores for the non-distressed New Zealand couples (Blampied et al, 1983). Nevertheless these results show that over the course of treatment marital satisfaction increased. This positive effect also showed up as significant emotional improvements on the Self-rating Depression Scale (SDS). SDS and ACQ scores had the most durable gains.

The largest positive changes on MHS scores occurred during the pre-treatment period and these changes were of the same magnitude that occurred in Azrin et al (1973). During treatment, while for some couples there were large fluctuations in scores, they did not increase substantially above latter pre-treatment scores. When clients were asked about what had caused the marked decreases in their marital happiness, they frequently explained that during treatment they had become more

aware of some weakness or failing within their relationship. Therefore the initial rise during pre-treatment maybe due to an increase in collaboration between spouses and an increase in expectation of treatment. This is supported by the fact that the largest increases in MHS scores, reported by Azrin et al (1973), occurred during the first week of Reciprocity Counselling. The fluctuations during treatment probably reflect the couples accommodating a more honest view of their marriage and facing up to problem issues.

Scores at post-treatment and follow-up stabilised at upper levels of their marital happiness. Because these final scores were not unrealistically high, it suggests that the MHS gives a valid measure and is not greatly affected by demand-effects. However, if it is continued to be used clinically and in research it will need further validation research. The results from the CTD and IRA did not clearly show an increase in the rewarding time spent together by couples, nor was there an increase in the frequency rewarding activities done together.

Blampied et al (1983) reported that although "the mean differences were in the predicted directions", these instruments were not strong discriminators between distressed and non-distressed marriages. Likewise SOC data did not show any significant gains either in increases in 'pleases' or decreases in 'displeases'. The best results were from Couples A and D and these were only small changes. The clients described the SOC as time consuming and two couples declined to use it during follow-up.

The accompanying observation checklist was used inconsistently, so that their descriptions of pleases and displeases tended not to be behaviourally specific. Because of

this and the fact that:

(1) between-couple please frequency correlations were lower than with-in-couple correlations.

(2) the daily SOC data recorded generally decreased over time.

(3) the mutual please level was variable and

(4) there was a low frequency of data

the reliability and validity of the SOC as used in this research would be questionable. Jacobson and Moore (1981) made a similar observation. This makes it difficult to compare this data with other studies utilising it. Nevertheless, using Stein, Givodo & Dotzenroth's (1982) retest reliability study as a comparison, our mean number of pleases per day (which ranged from 1.2 to 14.6) were well below their average of about 30.0 please per day. Putting aside these psychometric concerns the CTD, IRA and SOC failed to show a definite increase in mutual reinforcement and positive reciprocity, or a definite decrease in negative spouse emitted behaviours following treatment.

Generally the target behaviour data reveals that intervention had little effect. When there were slight changes in the desired direction they began before contracts were made. However, it would be unrealistic to place too much significance upon these results. Unlike Jacobson (1977, 1978) whose primary focus in therapy was to use behavioural principles to alter problem behaviours in the marriage, the CRESST programme was designed so that problem definition, the tracking of specific behaviour and contracting were more exercises to aid the teaching of behaviour control principles rather than primarily therapy.

Additionally there were technical weaknesses throughout this task. A major handicap was that the time allocated

in the programme for these exercises was not long enough. The identification and description of problem behaviours was a slow and difficult process, often taking in our research from 2 to 3 weeks to finalise. Clients were reluctant to put forward actual examples of how their partners displeased them. Once chosen, it was sometimes found that the naturally occurring rates of these behaviours did not differ by much from the desired level. One could only ask the question, "Were these problems, in the first place?". In these instances it was of clinical benefit if couples could change their expectations of what was realistic in the marriage. The clients had similar difficulty in choosing appropriate reinforcements and agreeing on contracts specifying their contingencies. In most cases the adherence to the contracts was questionable.

The communication training component of the treatment had some success. Most couples had small but apparent increases in positive communication, and the decreases in negative communication. The most marked consistent changes occurred in rates of Communication Talk. Many of the component skills that communication training tried to teach seemed to be already in the couple's behavioural repertoire (i.e. feeling talk and asking questions). However, many of the skills in Communication Talk (i.e. paraphrasing) and Solution Generation either were not skills they had or occurred at a very low rate. The best results in our study were achieved in teaching new skills rather than increasing the rate of naturally occurring components of communication. The self-ratings of each spouse's "happiness with communication" (MHS) showed little correlation with the actual behavioural data. This tends to suggest that the self-ratings of the MHS were accounted more by 'marital satisfaction' at that point of time than anything else.

One of the strengths of this research was the construction and use of a communication coding system which analysed audio-tapes. While the Marital Interaction Coding System (MICS, Patterson, 1976), by using Video-recordings, can analyse more non-verbal components of interaction coming from facial expression and posture, this lack of coded nonverbal information did not seem to restrict the utility of our system. In the instances during taping when there was alot of negative affect displayed nonverbally by clients, this showed up in our data either as increased negative communication rates or (when a client was less verbal) decreases in positive communication as compared to their normal rates. Blampied et al (1983) concluded, "Given the expense and difficulty of using direct behavioural observations in clinical settings the present data do not justify any recommendation that clinicians should attempt to use MICS-type observation procedures in their work" (P.18).

Along with Guerney (1982), however, the author would argue the need for some sort of objective behavioural assessment of the effectiveness of communication training, even in clinical practice. Audio-tape analysis may fulfill the need for objective assessment of communication. The use of audio-tapes is certainly cheaper and more convenient than using video-tapes and there is even the possibility of recording communication in the home. Although this study used continuous assessment during treatment, at least pre and post-treatment probes would be adequate clinically.

For all the effort that went into making and analysing the repertory grids there was relatively little in return from which one could generalise about the effectiveness of treatment. This is not to diminish its validity or usefulness.

As Slater (1971) has stated "It may seem perfectly reasonable to stipulate that a grid should be reliable and significant if important decisions depend on the results from it - for instance, if the diagnosis or treatment of a patient is concerned" (p.128). Therefore, while the repertory grid was not a time-efficient research tool it has a lot more potential if used clinically with couples to help clarify how each spouse perceives their relationship. Furthermore the subtle differences between such elements as 'your satisfaction of your partner' and 'your perception of your partner's satisfaction of his/herself' made filling it in tiresome and sometimes confusing. The resulting information gained from the repertory grids were similar in form to that gained from the Areas of Change Questionnaire, with regards to spouse-to-spouse perception. The ACQ was however, quick and easy to administer and did not need a computer to analyse it. The only advantages of the repertory grid were that the perceived-effect of others (as well as of each spouse) could be measured, and a multi-dimensional representation could be drawn.

The reconstruction grid, however, gave clear analysable results regarding change over treatment and at follow-up. There were two main trends in this data. The first occurring with Couples A and C showed some convergence of the respondent's satisfaction with spouse, and the perceived spouse's satisfaction with the respondent as well as a general increase of both their satisfaction in most areas of the marriage. However, with the other couples, there was a greater discrepancy between their satisfaction of one another. While there was a lot of change at post-treatment and follow-up, this was not in a uniform direction. The overall impression was that therapy was less effective for Couples B and D in

encouraging of both partner's perception to become more similar, than in the first case.

Little can be discussed regarding the durability of any improvements following training because follow-up was comparatively short and there was some data loss. Any comments about the generalisation of gains into the home environment should be limited to more objective observational and quasi-observational measures such as the communication analysis, SOC, and target behaviours.

Apart from the communication analysis, there was insignificant evidence of behavioural improvements within the marriages. Unfortunately as the communication data was solely based on laboratory assessment, it is only speculation that it generalised into the home. Along with set homework it may be profitable, in the future, to encourage generalisation by doing therapy with one or a few couples in their own homes, if couples agree to it. Post-treatment, follow-up assessments and booster sessions, at least, could be done in each couple's home as part of the contract.

All couples showed some improvement. The best results were demonstrated by the self-report measures especially the ACQ, MAT, SDS, which were of a comparable magnitude with those reported by Blampied et al (1983), and Jacobson (1979). Along with the reconstruction grids, these improvements were typified by an increase in marital satisfaction and a decrease in perceived conflict and dissagreement after training.

The multiple baseline procedures as used by Jacobson (1979) and Bornstein, Bach, Heider & Ernst (1981) gave a powerful demonstration of therapeutic effectiveness and were the epitome of good clinical practice as described by Hayes (1981). However, this research differed from Jacobson's and

Bornstein's, by using MHS, SOC and communication-analysis data for its multiple-baselines, instead of specifically identified problem behaviours. These instruments could only provide indirect or partial measures of behaviours.

Furthermore, because the intervention in this research was not tied to any particular behaviour, links between intervention and behaviour were also indirect. When Blampied and Haye (1982) reviewed the use of multiple baseline in BMT they stated, "The multiple baseline analysis,.....presented couple by couple, shows the inadequacy of the instructional training phase as a therapeutic intervention, since significant change occurred only as each target behaviour was made the focus of problem-solving training". Therefore it is dubious to use only instructional training as an intervention alone.

The CRESST programme provides a clear framework for training, but, it offers only the bare essentials. Yet, this allows it alot more scope for further development. This flexibility is a strength because the course could be easily redesigned to suit particular couples or groups such as alcohol-complicated marriages. In the present study couples found that 8-10 weeks was too long to sustain a high level of interest throughout. They reported that attending the course each week, doing homework and keeping a daily count on target behaviours and/or spouse pleases interferred to some degree with their normal routine. Using the programme in clinical practice, the author would consider dividing the course into 3 to 4 blocks of sessions and spacing these out over a few months. This would allow couples a longer time to work on each skill, with the expectation that there is more time for each skill to be incorporated into the relationship before

continuing to the next stage. There would hopefully be less interference with normal family life. It may also encourage maintenance. "Maintenance can be facilitated by gradually spacing sessions further apart.... This spacing allows the couple to use skills on their own for successively longer periods of time" (Lester et al 1980).

In this study the drinking problem was not the focus of therapy, the primary focus was the quality of each marriage. In all four couples the alcohol problem was under control. This is advantageous, because when an alcohol problem continues, the stimulus conditions remain to refuel distrust, resentment frustration and anger. Zweben and Pearlman (1983), nevertheless, have described the outline of a conjoint therapy approach that is the primary focus of alcohol treatment. An empirical evaluation of this approach will be most beneficial to the area.

Unfortunately, this study did not incorporate the last two sessions of the CRESST programme which covered the sexual relationship. The MHS scores for sex were generally low and they changed little over the course of training. Furthermore, the sexual relationship is particularly vulnerable in an alcohol-complicated marriage. First, a spouse may withdraw from having sex when his/her partner has been drinking, this can be a source of frustration and conflict (Hansen & Estes, 1977). Second, alcohol is a depressant, inhibiting physiological arousal, and may for example cause secondary impotence (Masters & Johnston, 1970). Third, sexual promiscuity may occur more readily (Estes & Baker, 1977). Therefore this component should be kept as an essential part of the programme.

This research attempted to study how effective a programme of marital therapy was. Yet, any therapy can be

limited by the proficiency of its therapists and the presentation. Both co-therapists were trained alcohol counsellors but had limited experience with conjoint therapy. Certainly, their proficiency would have increased as the study progressed. Regular supervision was an essential element of this study and would be regarded as desirable in clinical practice. While restricting the potential benefit of the CRESST programme, it could also be seen as a strength of this research, because by using alcohol counsellors with minimal practical experience in marital therapy it created realistic treatment conditions, and therefore the resulting effectiveness is the minimum that the public could expect if the programme was used by alcohol treatment agencies. The fact that there was no drop out once therapy commenced must be an indication of the client acceptance of it.

SUMMARY AND CONCLUSION

Four married couples from alcohol-complicated marriages took part in an 8-10 week course of communication and social skills training. They were studied using a wide array of measures. Multiple baseline analysis was used, but this was limited by the use of data which gave only partial measures of behaviour (i.e. MHS & SOC). All couples showed improvements especially in the areas of perceived conflict and marital satisfaction. This was of a comparable size with those reported by Blampied, Church and Haye (1983) in their study of behavioural marital therapy in groups using the CRESST Programme. However, our study did not find evidence of significant behavioural changes in the marriages. Due to short and incomplete follow-up data little could be

discussed regarding generalisation and maintenance. Some suggestions made for the further use of the CRESST are:-

(1) Adapt it to specific treatment populations or incorporate it into existing therapy.

(2) Spend more time on the identification and description of problem behaviour.

(3) Spend more time on the specification of goals and reinforcement/punishment schedules.

(4) Space out the CRESST programme to encourage maintenance.

(5) Try to run at least some of the sessions in the clients' homes, to encourage generalisation.

(6) Use audio-tapes to assess changes in communication.

(7) Use the whole programme particularly those dealing with the sexual relationship.

Dr Roxburgh in an article entitled 'Lifestyle the root of drug, alcohol abuse' (The Christchurch Press, 28/8/1982) wrote:-

> "Prevention of drug abuse (in which he included alcohol) is a most complex subject and we must be aware of approaching it with any simplistic ideas. No simple answer to the problem exists. In fact, it is unlikely to improve until society improves, - basically, that marriages and families improve".

Hindered by some weaknesses in the data set and incomplete follow-up data, this study demonstrated only limited therapeutic efficacy. However, given the realism of the therapy compared with what existing treatment facilities already offer, and the clinical gains in all couples, the results are encouraging. There is a need in the area of alcohol treatment for structured marital therapy and a continual evaluation of its effectiveness. This study has

attempted to show the applicability of Behavioural Marital Therapy, such as the CRESST programme, and the utility of some empirical assessment methods.

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The first four cartoons were printed during 1983 in the Christchurch Press. They are from "The Wizard of Id" series and were published by Allan Foley Pty Ltd. The final caption is from the book "Do You Want To Talk About It?" (Page 22), by Edward Koren, New York - Pantheon.

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APPENDIX A

MARRIAGE THERAPY CONTRACT

This is a contract for consent to undertake a 10-week course which will be part of a research project on therapy with married couples.

Description

1. Couples will usually work in small groups of 2 to 3 couples.

2. The course is a block of 10 weekly sessions.

3. Each session will be no more than 2 hours in duration.

4. Each session is divided into an education section (dealing with communication and related skills), and another section involving guided practice of these skills.

5. The therapists will participate in each session

CONTRACT

Each couple agrees to:

1. Attend each session.

2. Complete homework assignments and return the completed data weekly.

3. Allow data accumulated during the group to be used in the research project (protection of confidentiality is assured).

4. To maintain the confidentiality of the other group members.

We (as stated below) assert that we have (1) read and understood the outline and contract (2) and agree to participate in the therapy (3) and allow our data to be used in the research.

_____ _____

(Name) (Date)

_____ _____

(Name) (Date)

The group therapists agree to:

1. Begin and end each session on time.

2. Provide members with skills that offer the best chance of an effective and efficient resolution of present and future problems.

3. Demonstrate for the members how the skills are best used.

4. Provide group and individual coaching in order that each member attains a reasonable level in each new skill.

5. Respect the confidentiality of members' communication.

6. Provide further training if desired following group termination. Any further training would, however, not be considered part of the research project.

_____ _____

(Therapist) (Date)

_____ _____

(Therapist) (Date)

APPENDIX B

SESSION I

SHARING PLEASES

Expressing a Compliment:

(1) Decide what it is about your partner you want to compliment.

(2) Choose the right time and place to express the compliment.

(3) Express the compliment in a sincere and friendly manner.

Responding to a Compliment:

(1) Listen openly to the compliment.

(2) Tell your partner how the compliment makes you feel.

(3) Thank your partner in a warm and sincere manner.

Expressing Affection:

(1) Decide what kind of warm and caring feelings you have about your partner.

(2) Decide how you might best express your feelings.

(3) Choose the right time and place to express your feelings.

(4) Express your affection in a warm and caring manner.

Expressing Appreciation:

(1) Clearly describe to your partner what he/she did for you that deserves appreciation.

(2) Tell the other person why you appreciate what was done. (You could use the words, "I appreciate you for ..... because .....")

(3) If appropriate, ask your partner if there is anything you could do for him/her.

APPENDIX C

SESSION 2

GOOD COMMUNICATION

Preparing for a Discussion:

(1) Decide upon a realistic topic.

(2) Decide upon a reasonable time and place which is mutually agreeable.

(3) Arrange to minimise distractions.
(Turn off T.V., put the children to bed or tell them you don't want to be disturbed for half an hour, etc.)

Making a Statement:

(1) Sort out what you want to say.

(2) Be aware of how you are feeling (nervous, depressed, annoyed, frustrated,

(3) Where possible use "I" statements and refrain from generalising.

(4) If needed, then ask for your partner to comment on what you said.

Active Listening:

(1) Look at the other person.

(2) Show your interest in your partner's statement.
(Nod your head, use appropriate body language)

(3) If unsure about anything ask for clarification.

(4) Give regular feedback on the content and feelings expressed by your partne

(5) Then add your thoughts and feelings on the topic.

Clarification:

(1) Identify what part of the content you don't understand.

(2) Start with words like, "Do you mean .....?", or "Are you saying .....?"

(3) Followed by a summary of how you understand the message.

Paraphrasing (Feedback to Content):

(1) Identify the content of the message.

(2) Begin with words like, "You said .." or "I heard you say ..."

(3) Followed by a summary of the content.

Reflection (Feedback of Feelings):

(1) Observe the senders words and actions (posture, facial expressions, etc.)

(2) Identify how you think the sender is feeling, and what feelings are being expressed in the message.

(3) Begin with words like, "You feel ..... because ....."

(4) Make your statement of how you think your partner is feeling in a warm and sincere manner.

APPENDIX D

VERBAL INTERACTION TASK

(1) The couple mutually choose which partner will be the SENDER.

(2) Instructions to the SENDER:
Please discuss with your partner something you would like to change in yourself. Try to be open and expressive of your feelings as possible. You will discuss this for 5 minutes.

Instructions to the RECEIVER;
You are to try to help them express their feelings as much as possible. Especially use feedback and clarification.

(3) After 5 minutes the discussion will stop, and the group will give feed-back about it.

(4) The couple change roles as sender and receiver, and begin another discussion following the above instructions.

(2a) (Alternative Instructions)
Instructions to the SENDER:
Please discuss with your partner something you would like to see changed in them. You should not choose the same thing that they chose last time. Try to be as open and as expressive of your feelings as possible. You will discuss this for 5 mins.

Instructions to the RECEIVER;
Please discuss with your partner something they would like to see changed in you. You are to try to help them express their feelings as much as possible.

Based upon the 'Verbal Interaction Task' devised by B. Guerney (1977).

APPENDIX E

THE MARITAL GRID

Name: _____

(YOUR PERCEPTION OF.....)	YOU	SPOUSE	HOW YOUR SPOUSE SEES YOU	HOW YOUR SPOUSE SEES HIS/ HER SELF	AVERAGE N.Z. HUSBAND	AVERAGE N.Z. WIFE	
PROVIDING COMPANIONSHIP							
GIVING AFFECTION							
BEING CONSIDERATE							
SEXUALITY							
ABILITY TO COMMUNICATE							
USE OF LEISURE TIME							
CHILD CARE & PARENTING							
INVOLVEMENT WITH HOUSEHOLD MANAGEMENT							
FINANCIAL MANAGEMENT							
EMPLOYMENT & EDUCATION							
PERSONAL HABITS & APPEARANCE							
INDEPENDENCE							

THE MARITAL GRID

INSTRUCTIONS

SCALE:

1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied									Extremely Satisfied

INSTRUCTIONS:

(a) How would you rate your satisfaction with your .....

(b) How would you rate your satisfaction with your partner's...

(c) How do you think your partner would rate his/her satisfaction with your....

(d) How do you think your partner would rate his/her satisfaction with his/her own.....

(e) How satisfied do you think the average New Zealand husband is with his.....

(f) How satisfied do you think the average New Zealand wife is with her....

(1) providing companionship
(2) giving of affection
(3) being considerate
(4) sexuality
(5) ability to communicate
(6) use of leisure time
(7) child care and parenting
(8) involvement with household management
(9) financial management
(10) employment and education
(11) personal habits and appearance
(12) independence

APPENDIX F

UDIO-TAPE CODING SYSTEM

Positive Responses		Negative Responses	
Accept Responsibility	(AR)	Accusation	(AK)
Agree	(AG)	Complain	(CP)
Approve	(AP)	Criticise	(CR)
Communication Talk	(CT)	Deny Responsibility	(DR)
Feelings	(FG)	Excuse	(EX)
Positive Feeling	(PF)	Interrupt	(IN)
Problem Description	(PD)	Mind-Reading	(MR)
Question	(Q)	Negative Feeling	(NF)
Relationship Talk	(RT)	Put Down	(PU)
Solution Generation	(SG)	Side-Tracking	(ST)

Definitions

AGREE: "AG" is coded in a situation where one person expresses or advances an opinion and the subject's statement indicates agreement on the issue. It can follow a question or an assertion, or else it can be a change or opinion.

Do not score (1) an agreement that is immediately qualified by "BUT" or "HOWEVER" (2) "YES" in response to a question, unless the question is asking "DO YOU AGREE WITH ME?".

APPROVE: "AP" is a verbal response indicating that the respondent personally favours something the other has said or done. It may be a compliment or any statement expressing liking of the other.

They include, also, statements of "thanks" and can express approval for something the other may be planning to do in the future.

ACCEPT RESPONSIBILITY: When the question arises concerning the responsibility for a past or present problem, a person may explicitly accept the responsibility for this situation. This is coded "AR". It includes (1) accepting of joint responsibility, (2) statements of appologies and (3) accepting of criticism or pin-pointing of deficits. The subject may be accepting the responsibility to rectify or do something.

ACCUSATIONS: "AK" is coded which the subject tells his/her partner what he/she has done in an exaggerated or uncompromising way, without allowing the other a chance to agree; deny or comment. Code for the use of "ALWAYS" or "NEVER"

COMPLAIN: "CP" is used to code statements in which a person bemoans the extent of his or her suffering without explicitly blaming the other for this suffering. It is self orientated.

COMMUNICATION TALK: There are four classes of statements which are coded as"CT":

(1) A reflection of the feelings of what the spouse has said, or a statement indicating the need for further clarification of what the spouse has said or any nonverbal responses.

(2) A paraphrase of what was said.

(3) A summary of what both were saying; a statement regarding a joint decision.

(4) A comment about the process of the discussion. For example, how things are going, what they are doing, and what they have accomplished.

CRITICISE: A hostile statement expressing unambiguous dislike of the other, or disapproval of a specific behaviour in

which the other engages in, is coded "CR".

DENY RESPONSIBILITY: "DR" is coded, when the question arises concerning the responsibility for a past or present problem and a person explicitly denies that he/she is responsible for the situation.

EXCUSE: When the question arises concerning the responsibility for a past or present problem a person may avoid accepting the responsibility for it by invoking an implausible explanation, spurious reason, or weak rationale. If the explanation is plausible or reasonable it is coded "PD"

FEELINGS: An "FG" is a statement expressing emotion on the part of speaker. Do not score "FG" if "I FEEL...." is used to mean "I THINK....".

INTERRUPT: "IN" is an utterance of more than one word, made while the other is speaking. Both spouses are coded "IN" if they continue to both speak for more than one sentence. Such responses as "YES", "MMM..." and "I AGREE" are not scored "IN".

MIND READING: If one partner expresses what he/she believes is the others thoughts, values or opinions without leaving the other opportunity to clarify it or own it, it is coded as "MR". Do not code accusations or criticisms.

NEGATIVE FEELINGS: Code any nonverbal response which communicates displeasure, disgust or disapproval, usually in reaction to what the other person has said. Code such things as exasperated sighs or moans.

POSITIVE FEELINGS: "PF" is coded when there is evidence of positive feelings being shown towards a spouse. Particularly through the use of non-sarcastic humour. Otherwise,

code joking around and laughter as "PF".

PROBLEM DESCRIPTION: Any statement describing a present or past problem without criticising is coded "PD". Do not code the use of ambiguous cliches or traits. Nor, if the subject uses adjectives like "ALWAYS" or "NEVER".

PUT DOWN: "PU"is coded for a comment whose function is to demean or embarrass the other person. It may be an explicit insult or a comment with negative overtones.

QUESTION: "Q" is coded for any comment phrased as a question. It may be asking for new information, or a request for clarification like "DO YOU KNOW....?", "RIGHT?". Do not code any rhetorical questions that are answered by the speaker, or questions that have been asked before. Only code a question relating to one issue once.

RELATIONSHIP TALK: "RT" is coded for any statement discussing the couple. Code for the use of "US", "WE". It can be about the past, present or future plans.

SIDE-TRACKING: "ST" is coded when one partner makes a response that is not related to the issue being discussed at the time, or says something that hinders the continuance of a line of discussion. Do not code "ST" if the issue has been discussed to a reasonable conclusion.

SOLUTION GENERATION: Any statement that proposes a positive change of behaviour either in themselves or another is coded "SG". It must be realistic and reasonable. It also includes compromises.

THE END

"Darling, let's get divorced."